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**A comparative study of nursing workforce planning policies related to
recently qualified nurses in Scotland and Japan.**

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Submitted in fulfilment of the requirements for the Degree of PhD

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Abstract

This study investigated two cases in Scotland and Japan regarding government nursing workforce policies related to recently qualified nurses (RQNs) and the responses of clinical practice to these policies. Comparisons of findings and results between Scotland and Japan were made. Mixed methods were used including questionnaires (adapted POWCS and PES-NWI) and semi-structured interviews. In Scotland, five NHS managers, seven ward managers, and nine RQNs participated for the semi-structured interviews. A total of 119 Scottish RNs participated for the questionnaires. In Japan, seven nurse managers, six ward managers, and six RQNs participated for the semi-structured interviews. A total of 83 Japanese RNs responded to the questionnaires.

In Scotland, three government initiatives related to RQNs for the last 5 years were identified; ‘One Year Job Guarantee’, ‘Flying Start’(FS), and ‘Early Clinical Career Fellowships’(ECCFs). Several responses in clinical practice to these initiatives were identified from the interviews and questionnaires. Firstly, FS and ECCFs were understood as ‘good support’ by managers and RQNs. However, RQNs did not find FS helpful for supporting their transition process. Lack of engagement and poor understanding among RNs was found to be an issue as well as a lack of evaluation and tracking system for FS and ECCFs on completion of the programmes

In Japan, two major legislative changes related to RQNs for the last 5 years were identified; change in the Medical Care Fee Schedule for Remuneration and change in ‘Public Health Nurses, Midwives, and Nurses Act’ and ‘Nurse Provision Act’. An Increased number of RNs in the study hospitals was reported as an outcome for the Medical Care Fee Schedule for Remuneration. The increased annual inflow of RQNs caused issues such as increased workload for experienced nurses as well as a lack of the ability of experienced nurses as clinical educators for RQNs. Lack of funding and resources were found to be key issues for maintaining nurse staffing levels as well as the lack of a monitoring system for Japanese nursing workforce such as registration system.

Findings from this study suggested several factors for better policy development and implementation related to RQNs in Scotland and Japan; 1) there is a need to establish an evaluation or monitoring system for government initiatives in both countries, 2) the importance of developing and implementing nursing workforce policies without large fluctuations in nursing workforce was highlighted, 3) the Japanese government needs to develop more integrated nursing workforce policies, 4) the importance of having engagement from RNs with policies related to clinical practice was reported, 5) finally, this study suggests that Scottish and Japanese governments need to keep the attempts to sustain the changes by previous policies. The findings added to the current knowledge by providing the insight of each country related to recently qualified nursing workforce policy from two single case studies.

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List of Abbreviations

ANs	Assistant Nurses
ECCFs	Early Clinical Career Fellowships
FS	Flying Start
HDU	High Dependency Unit
ICU	Intensive Care Unit
JNA	Japanese Nursing Association
MHLW	Ministry of Health, Labour and Welfare
MIACS	Ministry of Internal Affairs and Communications, Statistics Bureau, Director-General for Policy Planning & Statistical Research and Training Institute
NES	NHS Education for Scotland
NHS	National Health Service
NMAHPs	Nursing, Midwifery and Allied Health Professions
OECD	Organisation for Economic Co-operation and Development
RMs	Registered Midwives
RNs	Registered Nurses
RQNs	Recently Qualified Nurses
UKCC	the United Kingdom Central Council for Nursing, Midwifery and Health Visitor

Research Notes

Research Note 1

The terminology for nurses was different in each country as the nursing education system is different from each other. In this study the terminology for nurses was defined in the following way.

Registered nurse (RN): a nurse graduated from a nursing programme college or nursing school and holds a professional nursing qualification. A RN provides nursing care to patients and the patient's family.

In Japan, **Registered Nurses** are defined as “persons who hold a license from the Ministry of Health, Labour, and Welfare, and engage in providing nursing care to or assisting in the medical treatment of persons with injuries and/or illnesses or postal women”.

In the UK, a person must hold a current and valid registration with the Nursing and Midwifery Council.

Licensed practical nurse/Licence vocational nurse; “*Licensed practical nurses (LPNs)*, or *licensed vocational nurses (LVNs)*, care for people who are sick, injured, convalescent, or disabled under the direction of physicians and registered nurses” (Bureau of Labor Statistics, 2009) (<http://www.bls.gov/oco/ocos102.htm>).

Assistant Nurse (AN). The term ‘assistant nurse’ is used only when the researcher is describing the situation in Japan. It is defined in the Public Nurse, Midwife, and Nurse Law as “a person who holds a license from prefectural governors and engages in providing nursing care to or assisting in the medical treatment of persons with injures and/ or illness or postnatal women under instructions from medical doctors, dentists and registered nurses.”

Unlicensed Assistive Personnel (UAP): UAP provides patient care under direction of nursing staff and performs duties such as feeding, bathing, dressing, grooming or moving patients, or changes linens. Certified Nursing Assistant (CNA), Nursing Care Attendant Certified Nurse Aide (NA), Nursing Aides, and Nursing Attendants are all common titles that are considered to be UAPs (Bureau of Labor Statistics, 2009).

In the UK, as in other countries, UAPs might also be called a Nursing Assistant (NA), Auxiliary Nurse (Aux-N), Patient Care Associate (PCA), Nursing Technician (NT), Healthcare Assistant (HCA), Healthcare Support Worker (HSW) or Clinical Support Worker (CSW)

Nursing Staff/ Nurses: In this study, Registered nurse (RN), licence practical nurse (LPN), and Unlicensed Assistive Personnel (UAP) are used to describe the nursing staff. When nurse or nursing staff are used, this includes only RNs unless stated otherwise. Inclusion of other nursing staff such as LPN and UAP is noted only when it is noted in the literature.

Recently Qualified Nurse: There are many terms to describe recently qualified nurses, e.g. newly qualified nurse, new graduate nurse, new nurse, novice nurse, recent RN graduates and recently qualified nurse (Roberts, Jones and Lynn, 2004; Suzuki, Itomine, Kanoya, Katsuki, Horii and Sato, 2006; Clark and Holmes, 2007; Beecroft, Dorey and Wenten, 2008; Lavoie-Tremblay, O'Brien-Pallas, Gelinas, Desforjes and Marchionni, 2008). Most of the literature does not have clear definitions of these terms.

In this study, recently qualified nurses are defined as nurses who have been qualified for 24 months or less. The following terms; 'newly qualified nurse, new graduate nurse, new nurse, novice nurse, recent RN graduates' are replaced by 'recently qualified nurses' (RQNs) in this study

Research Note 2

As one feature of this study, the researcher used various data sources, in particular government related websites, such as NHS Scotland, Ministry of Health, Labour, and Welfare. Additionally, the researcher also used some newspapers, individual blogs, and unpublished commentary. In order to provide an appropriate reference list, the researcher provides the reader with as much information as she was able to gain. Occasionally, footnotes are used to provide additional information and associated websites.

Chapter 1: Introduction

1.1 Personal Motivation for This Study

My original interest in this study arose from a curiosity as to why nurses appeared to be not happy with their job and why there had been always an issue in recruiting and retaining nurses. While I myself am working, I am also one such nurse who is dissatisfied with their job and planning to leave the job and nursing profession. I liked being a nurse and nursing, but not working as a nurse. Although nursing itself is a very rewarding and respected job, I could not see myself working as a nurse for the rest of my life. The reason why I felt this way could not be only because my career prospects were different from others, but also because I was not happy with working in that work environment in Japan. I decided to leave the job and do a Master's degree to do something different for myself and gain a broader view and understanding of nursing and the relationships with other disciplines. The experience of my Master's degree gave me a wider view and understanding of how nursing is related to politics, the healthcare system, economic situation, and culture. I realised my question, which was why there was always an issue in retaining and recruiting nurses, cannot be answered simply and solved. Since I understood the complex situation in healthcare system and health professional workforce, I started to develop my interest in the relationship between nursing and policy, and this is one of the reasons why I chose this as the topic of my PhD study.

Another reason why I chose this topic for my PhD study emerged from my personal experience while working as a nurse. As mentioned before, a shortage of nurses was the most well acknowledged issue among health professionals in Japan and it had gathered a lot of attention from the public due to legislative change in the healthcare system in Japan. The legislative changes in 2006 made a huge impact on the nursing workforce and the profile of nurses in hospitals. It also highlighted an issue in the nursing education system and the attention paid to newly qualified nurses. When I came back from the UK after completing my Master's degree, I was very interested in how this legislative change was brought into the ward level, and how the changes were perceived among nurses.

I decided to investigate the policies related to nursing workforce planning related to recently qualified nurses in Scotland and Japan as my PhD topic to see if I could suggest any different approaches for better development and implementation of nursing workforce policies.

1.2 The Aims of the Study

This study aimed to investigate the situations in Scotland and Japan regarding nursing workforce planning, with a particular focus on recently qualified nurses and their impact on ward level nurses.

The study aims was to identify similarities and differences between Scotland and Japan regarding the impact of government policies related to recently qualified nurses.

Chapter 2: Literature Review

2.1 Introduction

The literature review has several important functions; to identify the research problems and development of research questions, to identify the theoretical and conceptual framework for a research problem, and to identify the most suitable research methods and methodology to answer the research questions. It provides a reader with a background to the study, with an understanding of current knowledge on the research topic and clarifies the importance of the new study (Polit and Beck, 2004).

This chapter is composed of several sections which discuss various aspects of two countries, Scotland and Japan. The main issues related to this research cover areas in the healthcare research field, e.g. the healthcare system, health policy, nursing workforce as related to recently qualified nurses (RQNs). It has to be recognised that this study has many aspects to it, many of which deserves to be topics in their own right (e.g. policy implementation)

Firstly, the importance of nursing workforce in current healthcare delivery (2.3) and then key issues related to recently qualified nurses (RQNs) (2.4) are discussed broadly. In 2.5, nursing workforce policies and nurses' involvement in policies are discussed. General information on each country (Scotland, Japan), the context of the healthcare system, nursing system and key issues in the nursing workforce are given (2.6 and 2.7). In the same sections, government policies and related to the nursing workforce, in particular RQNs, are discussed. Finally, brief description of Japanese culture is presented in 2.7.8.

2.2 Search Parameters

A systematic literature search related to the current issues in nursing workforce was conducted using the following databases: OVID-MEDLINE, OVID-EMBASE, EBSCO-Cumulative Index to Nursing & Allied Health Literature (CINAHL), Web of Science. Additionally, relevant books, government websites and other professional associations' websites were used. NII Scholarly and Academic Information Navigator (Cinii) and Japana Centra Revuo Medicina (ICUSHI) were used for searching relevant Japanese literature. However accessing Japanese literature proved to be difficult as the system requires an individual to be employed within the organisation [and the researcher was a student in the

UK, not an employee] for easy access. Not all Japanese nursing journals are available online and the universities tend to rely on paper-copy nursing subscriptions. The researcher was given permission to access the Osaka Prefecture University library where articles could be obtained but a combination of distance, time and the fact that many of the journals are targeted at the professional nurse, meant the volume of literature was limited.

The main searching topics were ‘Nursing Workforce’, ‘Policy’ and ‘Newly Qualified Nurses’. For each topic, a set of keywords was used. The literature was limited to the most recent papers published from 2003. However, classic literature, which was referenced in articles many times and the researcher recognised often, were included for the review. Keywords were amended several times over time to maximize the accuracy of search strategies. Additional keywords were introduced based on the references that were identified from the literature search. Other relevant papers were identified by hand searches from the reference lists of the reviewed literature. The same keywords were used for literature searches in Japan and Scotland. Table 2-1 shows the inclusion and exclusion criteria for the literature search.

Table 2-1: Inclusion and exclusion criteria for the literature

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> • The sample should include <ul style="list-style-type: none"> ○ Registered nurses or ○ Hospital based nurses or ○ Nurses in general medical, surgical unit, and Intensive care unit • Primary or secondary research • Written in English or Japanese • Published from 2003-2011 	<ul style="list-style-type: none"> • The sample excludes Paediatric/ mental health/community /public health/hospice/ nursing home/ nurses. • Pilot study • Unpublished Doctoral dissertation or thesis

The following set of keywords was used to search particular topics (Table 2-2). The researcher was given advice from the librarian at the time to establish the search strategies.

Table 2-2: Keywords for the literature search

Main Topic	Keywords	Database
Nursing workforce and outcomes	nurs* outcome* staff* or ratio quality of care nurse practice environment	OVID-MEDLINE OVID-EMBASE EBSCO-Cumulative Index to Nursing & Allied Health Literature (CINAHL) Web of Science
Nursing Workforce Challenges	challenges* or issu* shortage government	OVID-MEDLINE OVID-EMBASE EBSCO-Cumulative Index to Nursing & Allied Health Literature (CINAHL) Web of Science
Policy and Nursing	policy nurs* organisation* change*	OVID-MEDLINE OVID-EMBASE EBSCO-Cumulative Index to Nursing & Allied Health Literature (CINAHL) EBSCO-Business Source Premier Web of Science
Recently Qualified Nurse's Experience	newly graduate nurse* newly qualified nurse* novice nurse* recently qualified* transition experience	OVID-MEDLINE OVID-EMBASE EBSCO-Cumulative Index to Nursing & Allied Health Literature (CINAHL) Web of Science

2.3 Importance of the Nursing Workforce in Health Care Delivery

In this section, the importance of the nursing workforce in healthcare delivery is discussed broadly. Reference is made to the UK (Scotland) and Japan as appropriate.

There is consistent evidence that the nursing environment (e.g., nursing staffing level, nurses' educational background, the quality of nursing care, nursing delivery model, etc.) makes a significant impact on health care delivery, especially patient outcomes. This evidence emphasizes the important role of nursing in improving the quality of care as well as whether less qualified nurses and healthcare assistants can replace nursing staff. The majority of these studies were conducted to examine the relationship between nurse staffing levels and patient care outcomes. In the next section, the relationship between nurse staffing levels and patient outcome is discussed.

2.3.1 Systematic Reviews of Nursing Environment (Nursing Staffing) and Patient Outcome

In this research field, there are several systematic and integrative reviews that have examined the relationship between nurse staffing and patient outcome (Lang, Hodge, Olson, Romano and Kravitz, 2004; Lankshear, Sheldon and Maynard, 2005; Numata, Schulzer, van der Wal, Globerman, Semeniuk, Balka and Fitzgerald, 2006; Kane, Shamliyan, Mueller, Duval and Wilt, 2007; West, Mays, Rafferty, Rowan and Sanderson, 2009). Most focus on nurse staffing in hospitals and on medical and surgical patient outcomes.

Systematic Reviews without Meta Analysis

Lang (2004) conducted a systematic review to investigate the minimum nurse and patient ratio for acute care hospitals and examined whether nurse staffing levels were associated with patients, nurses and hospital outcomes. The review was based on literature published 1980-2003 and studies conducted only in the United States (USA). MEDLINE, CINAHL, Web of Science and ABI/Inform databases were searched. Other relevant papers were identified by hand searches of references. Initially 2,897 articles were identified and 490 papers were retrieved after reviewing the abstract only. The studies conducted in intensive care units, critical care units, nursing homes, and long-term care facilities were excluded from the data analysis. A total of 43 papers out of 490 met the inclusion criteria for data analysis. At least two authors were involved in paper retrieval. The articles that met the inclusion criteria for data analysis were extracted and coded using a standardised form. Most reviewed studies used total nursing staff levels, consisting of all registered nurses (RNs); or a combination of RNs and Licensed practical nurse (LPNs)/Licence vocational nurse (LVNs) and Unlicensed Assistive Personnel (UAPs); or 'skill mix' which is generally measured by the portion of the nursing staff that consists of RNs. Three authors assessed the clinical importance and statistical significance of these coded results independently and differences in grading were discussed later. Then the studies were categorised into one of six groups; clinically unimportant and either statistically significant or not; clinical importance uncertain and either statistically significant or not; or clinically important and either statistically significant or not. The association between a 10% difference in staffing levels with significant changes in patient outcome was considered as 'clinically important'.

The evidence supported the relationship between increased nurse staffing and a lower rate of ‘failure to rescue’ (death within 30 days among patients who experienced complications) at least with surgical patients; inpatient mortality; and shorter hospital stays. However, the evidence failed to provide a consistent effect of increased nurse staffing levels on improved patient outcomes such as pneumonia, urinary tract infections and pressure ulcers. This systematic review identified that half of the studies used hospital administrative data rather than data from the each nursing unit. Thus it brought a concern that the results might be misinterpreted because hospital administrative data included data from special units such as theatre and intensive care units that have different nursing shift patterns and different patient characteristics. It has to be noted that this systematic review only dealt with studies conducted in the USA and the studies conducted in intensive care units and critical care units were excluded without a clear reason even though the review focused on acute hospitals. Thus the result can only reflect on the situation in the USA.

In contrast to the previous systematic review, Lankshear, Sheldon and Maynard (2005) included all studies published in any language from 1990 to 2004 (Lankshear et al., 2005). The review was performed to assess the evidence of the relationship between nurse staffing levels and patient outcome in acute hospitals. MEDLINE, CINAHL, EMBASE, PsycINFO, HMC, SINGLE, Cochrane Library, British Nursing Index and NML Gateway Web of Knowledge were used. Additionally, government and organisational websites were searched to identify any grey literature. A predesigned table was used to extract the data from the studies. The nurse staffing level was adjusted into two measurements; either hours per patient day (HPPD)-that is the average number of hours of nurses on duty per patient; or converted hours per patient day (CHPPD)-that is converted from a nurse to patient ratio. These measurements allowed the reviewers to analyse and compare data in a qualitative synthesis since meta analysis was not applied due to the variety of study designs. A total of 8,644 articles were initially identified for potential analysis. After the review of the title and abstract, 422 articles were selected and after the inclusion and exclusion criteria were applied, 61 articles were identified. Of these, 38 articles were included because the study was conducted in acute general hospitals. A total of 22 articles out of 38 articles were conducted in multi-site studies and were adjusted for case mix. Of these, four articles used secondary data from the two different studies, thus they were counted as one set for each study. Thus, sets of 20 studies were included for analysis. The reported CHPPD ranged from 6.2 to 8.4. The evidence supported that an increased CHPPD was associated with patient outcomes such as decreased mortality, decreased rate of failure to rescue and pneumonia. However, it was noted that the reliability of the effect size of nurse staffing

levels was not estimated. This systematic review included literature in any language but it would have been useful for the countries to have been identified specifically rather than only in the reference list.

The previous two systematic reviews did not employ meta-analysis due to the variation of the measurement of nurse staffing levels and patient outcome. However, there are two systematic reviews with meta analysis conducted by Numata, Schulzer, van der Wal, Globerman, Semeniuk, Balka and Fitzgerald (2006) and Kane, Shamliyan, Mueller, Duval and Wilt (2007). In the next section, these two literature reviews are discussed.

Literature Reviews with Meta Analysis

Numata et al (2006) conducted an integrative review and meta analysis to examine the association between nursing staffing levels in critical care settings and patient mortality. The literature search was conducted through electronic databases, and hand searches retrieval of references from the available sources. The Cochrane Database of Systematic Reviews, MEDLINE, EMBASE, CINAHL, and PsycINFO were used. The published years differed with each database and ranged from 1966 to 2005 and the published language was limited to English. Two reviewers were involved in screening for relevant literature. A total of 251 citations were identified from the electronic data search. Of these, 233 were excluded after screening and discussion. An additional six citations from hand searches were included so that 24 citations were identified for the full text review. Twelve were excluded on full text review for the various reasons such as the lack of quantitative measures for nurse staffing measurement, non-primary research and the study investigating the association between skill mix and patient mortality. In the end, 11 articles and one conference abstract were identified for data extraction. Three studies were then excluded because they were conducted in neonatal intensive care units or intensive care nurseries as these units were considered distinct from other intensive care units. Data extraction used a standardised approach. The nine studies were conducted in Brazil, Scotland, Austria, and the USA. Unadjusted risk ratio was used for the initial analysis rather than the odds ratio to avoid over estimation.

Four studies showed that there was a statistically significant risk reduction in hospital mortality among patient with high nurse staffing levels and overall risk ratio was 0.65 (0.47-0.91). Results showed that there was insufficient evidence identified to support an independent association between nurse staffing levels and critically ill patients' mortality

after adjusting for other factors. However, as the reviewers stated, the number of reviewed studies was small and they only focused on specific health care settings such as critical care, thus limiting the findings of the review.

Kane et al (2007) conducted a systematic review to examine the association between registered nurses' staffing and patient outcomes in acute care hospitals. The articles were limited to studies conducted in the USA and Canada and published from 1990 to 2006 in English. MEDLINE, CINAHL, Cochrane database, BioMed Central were used for electronic searches. Additionally, grey literature was included. A total of 101 papers were reviewed. Of these five were excluded because of inadequate data presentation. Thus 96 articles were included in the meta analysis. Of these, 28 reported adjusted odds ratio for patient outcomes. The data were extracted using a standardised abstraction protocol. Two abstractors extracted the RN to patient ratio and adjusted odds ratio of patient outcomes. The results showed a consistent association between higher RN staffing levels and a reduction in the adjusted odds ratio of hospital-related mortality. An additional RN per patient day (assuming 37.5 hours per week, 48 working week per year, and 8-hour shifts) was associated with a reduction in the odds of mortality in ICU, surgical and medical patients by 9% (OR: 0.941, CI: 0.86-0.96), 16% (OR: 0.84, CI: 0.80-0.89) and 6% (OR: 0.94, CI: 0.94-0.95) respectively. In addition, higher nurse staffing levels were associated with a lower odds ratio of adverse patient events. An additional RN per patient day was associated with a reduction in the odds of hospital acquired pneumonia by 19 % (OR: 0.81, CI: 0.67-0.95-8) with all patients and 30% (OR: 0.70, CI: 0.56-0.88) with ICU patients. The odds of unplanned extubation with ICU patients and nosocomial bloodstream infection with surgical patients was decreased by 41% (OR: 0.49, CI 0.36-0.67) and 36% (OR: 0.64, CI: 0.46-0.89) respectively.

Numata et al's (2006) and Kane et al's (2007) systematic reviews suggest different evidence regarding ICU patients. Numata et al. identified that there was no consistent evidence of an association between higher nurse staffing levels and lower ICU patient mortality. On the other hand, Kane et al. reported an association between increased RN staffing and lower hospital-related mortality in ICU. The disparity between these two reviews could be explained by the methodological issues in the nursing staffing and patient outcome studies. In the next section, the methodological issues related to the previous systematic reviews are presented.

Methodological Issues

Several methodological issues arose in the research on nursing staffing and patient outcomes as discussed in the systematic reviews.

Firstly, there is a study design limitation. Most studies reviewed are cross-sectional using collected administrative data, which are collected from the hospital as a whole. Large randomised controlled trials to investigate the effect of nursing staffing levels on patient outcomes are unlikely to be conducted due to ethical and practical concerns. However it was noted that longitudinal or experimental research could obtain more robust data (Lang et al., 2004; Lankshear et al., 2005).

Secondly, diversity in measurement of nursing staffing levels is problematic since the inclusion criteria for nursing staff vary depending on study site (Lankshear et al., 2005); e.g. the lack of a standardised definition for what counts as a nurse. Nurse and patient ratios, nursing hours per patient day, the number of full time RNs are common measurements. However, as noted above each measurement has a different meaning in each study (Lankshear et al., 2005). As another example Numata et al (2006) pointed to the variation of the nurse to patient ratios among reviewed studies such as nurse to patient ratio during the night shift, nurse to patient ratio day shift and the average across all shifts.

Thirdly, the source of staffing data was identified as a potential risk to the strength of the association between nurse staffing and patient outcome (Kane et al., 2007). It was pointed out by Lang (2004) that many studies carried out in the USA collect staffing data from the American Hospital Association (AHA) so that the staffing data presents as a whole rather than a actual study site such as ICU or surgical unit (Needleman, Buerhaus, Mattke, Stewart and Zelevinsky, 2002; McGillis, Doran and Pink, 2004). Kane et al (2007) also reported that using a different data source to obtain the nurse staffing data, not from the AHA, could make a difference to the strength of the association (Kane et al., 2007). Additionally it is difficult to gain precise information from administrative data: for example how many hours are actually spent on direct nursing care during a shift.

Finally, it was noted that adjustment for confounding factors should be taken into consideration carefully. Numata et al (2006) stated that unmeasured or uncontrolled confounding factors such as patient and hospital characteristics should not be underestimated; for example, the intensity of medical doctor staffing may be

underestimated. The lack of attention to medical doctor staffing in the critical care settings was pointed out as a weak point in the many studies across this area (Lankshear et al., 2005; Numata et al., 2006).

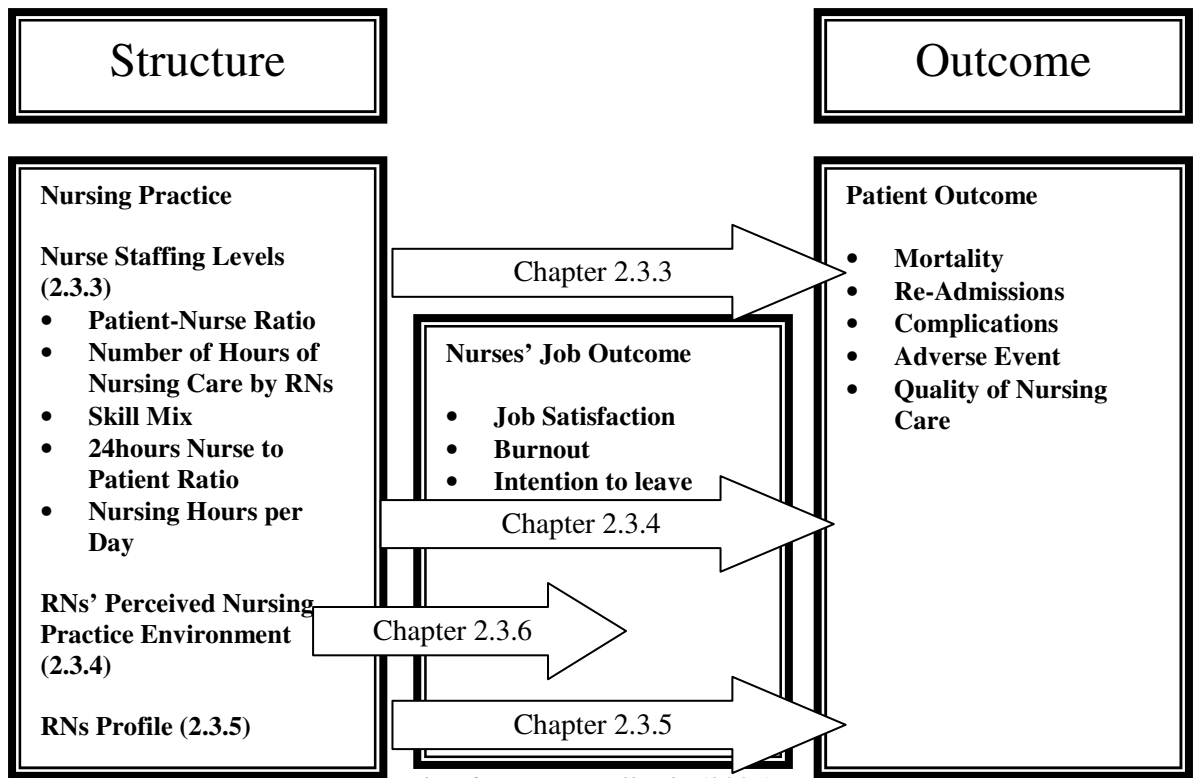
Key Messages and Summary

In summary, there is consistent evidence identifying a link between higher RN staffing levels and improved patient outcomes such as ‘failure to rescue’ mortality, and pneumonia. However, there are also mixed results for medical and surgical patients. These variations could be explained by the complexity of the care settings and/or methodological issues in collecting research data. Lack of standardised measurements for ‘nurse staffing levels’ and other confounding factors related to patient outcomes and hospital characteristics need to be taken into consideration for further research.

For the next few sections, studies on nursing environment including RN staffing and patient outcomes are discussed individually along with negative job outcomes among RNs.

2.3.2 Framework for Organising Literature related to Nursing and Patient Outcome

Kazanijian, Green, Wong, and Reid (2005) established a conceptual model based on the Donabedian model (1996) in order to examine whether workplace attributes affect patient outcomes. Donabedian (1966) established a theory that there is a link between structure, process and outcomes in terms of assessing the quality of care. Structure indicates the characteristics of the setting where the care is provided; that includes material resources such as facilities, equipment, and money; human resources; organisation structure such as staff organisation and methods of peer reviews. Process indicates the actual activities that are done while care is being given and received; that includes patients’ activities and practitioner activities such as diagnosing and implementing the interventions. Outcome indicates the result of care for patients; that include changes in patients’ knowledge and behaviour, and the degree of patients’ satisfaction with care. Better structure increases the likelihood of leading to a better process and better outcomes. In other words, the structure has an influence on the activities by the hospital staff, and it may lead to better patient outcomes. The following figure shows the modified conceptual model established by Kazanijian based on the Donebedian model.

Figure 2-1: Conceptual model indicating how patient outcomes may be related to nursing

Source: Redrawn with modification from Kazanjian's (2005)

2.3.3 Hospital Nursing Environment- Nurse Staffing Levels and Patient Outcome

There are two studies (Aiken, Clarke, Sloane, Sochalski and Silber, 2002b; Needleman et al., 2002) that are included in systematic reviews (Lang et al., 2004; Lankshear et al., 2005) which are now discussed in greater detail because they are cited often as evidence that shows the association between nursing staffing levels and patient outcomes, such as patient mortality.

Aiken et al (2002b) examined the association between the patient to RN ratio and patient mortality, failure to rescue and nurse retention factors. It was a cross-sectional study including RNs (n=10,184) and patients (n=232,342) who had general surgical, orthopaedic or vascular procedures in 168 general hospitals in Pennsylvania, USA. Hospital data were collected from the 1999 American Hospital Association (AHA) annual survey and 1999 Pennsylvania Department of Health Hospital survey. All 210 adult general hospitals were included initially in the study, but 42 hospitals were excluded because either they did not have surgical patient discharge data or they had fewer than 50 beds or they had survey data on less than 10 RNs. RN staffing was calculated directly from the mean patient load for all RNs from the last shift they worked. All nurses who had responsibility for at least one but fewer than 20 patients were included in the calculation. Hospitals were categorised according to size of the hospital, the ratio of resident physicians and other special functions

such as operations for heart surgery and major transplants. In addition, questionnaires were distributed to 50% of a random sample of nurses on the Pennsylvania Board of Nursing rolls which asked them to identify the hospital where they work, demographics, work history, workload, job satisfaction and job related feelings such as burnout. Discharge data of patients were collected from local government institutions from April 1998 to November 1999. It was revealed that RN staffing levels affected patient mortality and death following complications; that is even if the effect size of RN level was decreased after adjustment of patients and hospital characteristics, there was a 7% increase in mortality (Odds Ratio (OR), 1.07; 95% confidence interval (CI) 1.03-1.12) and a 7 % increase in the odds of failure to rescue (OR, 1.07 CI, 1.02-1.11) per additional patient per RN. In other words, one additional patient per RN increased mortality and the risk of 'failure to rescue'. The study was well conducted and presented but was conducted in only one. American region. However, the study results have been replicated (Aiken, Clarke, Cheung, Sloane and Silber, 2003).

On the other hand, in another study conducted in the USA, the relationship between nurse staffing and patient outcome was different from the previous Aiken et al's study. Needleman et al (2002) conducted a study in 11 states using 1997 administrative data from 799 hospitals, covering medical (n=5,075,969) and surgical patients (n=1,104,659). The study set out to examine the relationship between the number of hours of nursing care and 14 patient adverse events, usually sensitive to nurse staffing levels such as urinary tract infection, hospital acquired phenomena and upper gastrointestinal bleeding. The level of nurse staffing was estimated by the hours of nursing care provided by RNs, licensed nurses and nurse aides. A standard 2,080 hours (52 weeks at 40 hours per week) was used to estimate nursing staffing. Among medical patients, a significant relationship was found between a greater number of nursing care hours by RNs per day and three outcomes; shorter length of hospital stay (Regression coefficient, -.009; 95%CI, -.013 to -.005; $p < 0.001$), lower rate of urinary tract infections (Regression coefficient, 0.99; 95%CI, 0.98 to 1.00; $p < 0.003$), and lower rate of upper gastrointestinal bleeding (Regression coefficient, 0.98; 95%CI, 0.97-0.99; $p < 0.007$). Additionally, among surgical patients, it was found that there was an association between a greater number of nursing care hours provided by RNs per patient and a lower rate of 'failure to rescue' (Incidence rate ratio, 0.98; 95%CI, 0.96-0.99; $p < 0.008$). However, no associations between the number of nursing hours provided by RNs per day and the lower rate of 'failure to rescue' with medical patients (defined as death from pneumonia, shock or cardio arrest, upper gastrointestinal bleeding, sepsis, or deep venous thrombosis) and hospital death with

medical and surgical patients was found. They did not find any significant association between nurse staffing by nurse aides and licensed nurses and adverse events (data were not shown in the original article).

These two studies (Aiken et al., 2002b; Needleman et al., 2002) suggest there is an association between nursing staffing level and patient outcomes. Aiken et al (2002) reported that hospitals with a greater number of patients per RN experience higher risks in mortality and 'failure to rescue' whereas Needleman et al (2002) reported that patients with a greater number of nursing care hours provided by RNs, experience shorter length of stay and lower risk of unitary infection. Additionally, Needleman et al suggested that a skill mix with a higher number of RNs is associated to improved patient outcome. These findings fit in with the results of the systematic reviews (Lang et al., 2004; Lankshear et al., 2005; Numata et al., 2006; Kane et al., 2007)

McGillis et al (2004) showed different results related to nurse staffing levels and patient outcome in terms of the staffing skill mix. A descriptive co-relational study was conducted in 77 adult medical, surgical and obstetric patient care units in 19 Canadian teaching hospitals to examine the effect of nurse staffing mix on patient outcome. Nursing skill mix was measured by the following variables; RNs and registered practice nurse (RPN), only RNs, the portion of regulated to unregulated staff (URW), and a RN/RPN/URW staff mix by a questionnaire distributed to unit managers. Patient outcome was measured by medication errors, wound infection and urinary tract infections using administrative (hospital records) data. It was found that a higher proportion of professional nurses (defined as RN and registered practical nurse) was related to a lower rate of medication error ($t=-3.25$; $p<0.05$) and wound infections ($t=-.2.5$; $p<0.01$). The relationship between the length of experience as a nurse and patient outcome was also examined. However the results did not show any significant relationship between them. Even though the study showed interesting results, reporting of the methodology was rather poor; for example, the number of patients and nurses was not given and the categorisation of nursing staffing mix was not clear.

In the 1990s most evidence from studies examining the association between nurse staffing and patient outcome was North American. In the 2000s some studies in Europe and other countries emerged (Hugonnet, Chevrolet and Pittet, 2007; Rafferty, Clarke, Coles, Ball, James, McKee and Aiken, 2007; Cho, Hwang and Kim, 2008; Cho, June, Kim, Cho, Yoo, Yun and Sung, 2009; Van den Heede, Sermeus, Diya, Clarke, Lesaffre, Vleugels and

Aiken, 2009). However, the number of non-American studies in nursing staffing is small and the quality is rather poor, for example Shuldham, Parkin, Firouzi, Roughton and Lau-Walker (2009).

Some results of these studies are not always consistent with findings from North American studies and systematic literature reviews.

Hugonnet, Chervolet and Pittet (2007) conducted an observational, prospective cohort study in Switzerland with patient records ($n=18,883$) over four years from one intensive care unit. Patients who were kept more than 48 hours in ICU were included to examine the risk of infection related to nurse staffing levels (included non-certified nurses in critical care). Nurse staffing levels were measured by the '24-hour nurse to patient ratio'. The total number of nurses (definition of nurses was not given) working within 24 hours was divided by the patient census. Thus the greater the '24-hour nurse to patient ratio', the higher the nurse staffing levels. It was found that higher nurse staffing levels decreased the risk of acquiring infection in ICU by 30% (incidence rate ratio, 0.69; 95% confidence interval, 0.50-0.95). It was concluded that maintaining high nurse staffing levels could avoid a certain proportion of infection. Even though the study showed the same result - an association between higher nurse staffing levels and lower risk of infection on patient outcome - as Needeleman et al (2002), and the sample size was large, the study was conducted only in a single unit. It was noted that this limited the generalisation of the results to other units. Additionally, the details of nurses (whether it includes only registered nurses or not) was not given.

Rafferty et al (2007) conducted a cross-sectional study in 30 English acute hospitals to examine the impact of nurse staffing levels on patient mortality, failure to rescue (defined as death among patients who experienced complications) and negative job outcomes such as job satisfaction and burnout. The study included 3,984 nurses (RNs and enrolled nurses) and 118,752 patients. The 30 hospitals were from four different regions and were a purposive sample. All nurses working on surgical and medical units at each trust were included in the study. Nurse managers, paediatric nurses, psychiatric nurses, and midwives were excluded. The nurse staffing data included only data from nurses who had responsibility for patients' clinical care and was collected by questionnaire. Nurses reported their workload from the last shift such as the number of patients on the ward, the number of patients assigned to the nurse, and the total number of nurses on the ward. Using data directly from nurses was a major methodological difference from other early studies,

particularly American (Aiken, Clarke and Sloane, 2002a; Aiken et al., 2002b), in nurse staffing as Rafferty et al collected data directly from nurses rather than using administrative data. The nurse staffing levels were categorised into four quartile groups from high patient nurse ratio to low patient to nurse ratio. The lowest patient to nurse ratio was 6.9-8.3 patients per nurse, the second lowest was 8.6-10.0 patients per nurses, the third lowest was 10.1-12.0 patients per nurse, and the highest was 12.4-14.3 patients per nurse. The results showed that hospitals with the highest patient to nurse ratio were associated with a 26% higher mortality compared to the hospitals with the lowest nurse to patient ratio (OR 1.26, $p=0.002$). The study showed the same impact on patient outcome as conducted in the USA (Aiken et al., 2002b). However, it also has to be noted that there were no significant differences between the groups with the lowest patient to nurse ratio and those groups with the second or third lowest patient nurse ratio.

A study conducted in Belgian acute hospitals showed different results from other studies (Aiken et al., 2002b; Needleman et al., 2002; Rafferty et al., 2007). Van den Heede (2009) conducted a cross-sectional study in Belgium to examine the association between nurse staffing and patient outcome. The data analysed were from the Belgian Nursing Minimum Data Set and the Belgian Hospital Discharge Data Set in 2003. The data included 1,403 acute care and intensive care units and 260,923 patients from all 115 acute hospitals. Patient outcome was measured by 10 indicators; pressure ulcers, shock, cardiac arrest, postoperative respiratory failure, four infection measures (hospital acquired pneumonia, ventilator associate pneumonia, urinary tract infections, hospital acquired sepsis), 'in hospital mortality' and 'failure to rescue' (defined as the probability of death after a complication). Nurse staffing was calculated based on two data sets; 'Nursing Hours Patient Day' - the hours of care provided by RNs divided by the number of patients being cared for, 'Proportion of RNs with a Bachelor's degree'. Patient and hospital characteristics were also identified in order to adjust the association between nurse staffing and patient outcome. The results did not show any association ($p>0.1$) between nurse staffing levels and any adverse events. It was suggested that the disparity of the results between this and other studies could be explained by the variation of nurse staffing levels among study hospitals which was smaller than in other countries. Other variables such as nurse staffing variation within hospitals and the Belgian finance mechanism for the hospitals were also suggested as possible explanations for the disparity. It was suggested that the use of different nursing staffing measures such as measuring the nursing staff level on each unit might have illustrated more of a relationship between nursing staffing and patient outcome (Van den Heede et al., 2009).

Key Messages and Summary

A large number of studies have found a relationship between nurse staffing levels and patient outcome, most of which were conducted in the USA or Canada (Aiken et al., 2002b; Needleman et al., 2002; McGillis et al., 2004). Several European studies added to the evidence of an association between nurse staffing and patient outcome (Hugonnet et al., 2007; Rafferty et al., 2007). However, it also has to be noted that there is a study that produced alternative evidence (Van den Heede et al., 2009). One recent study showed no relationship between nurse staffing levels and patient outcome (Van den Heede et al., 2009)

2.3.4 Hospital Nursing Environment and Patient Outcome

In the previous section, the researcher discussed the evidence of the association between nurse staffing levels and patient outcomes. In addition to nurse staffing levels, there is some evidence of an association between the nursing environment and patient outcome.

An observational study was conducted in the USA to examine the effect of working conditions including RNs' staffing, work overtime, wage, and organizational climate on patient outcome (Stone, Mooney-Kane, Larson, Pastor, Zwanziger and Dick, 2007a). Hospitals were recruited through the Association for Professionals in Infection Control and Epidemiology, Inc., Listserve, and the Centers for Disease Control and Prevention's (CDC) Nosocomial Infections Surveillance (NNIS) system. A total of 15,846 patients, 1,095 RNs, and 51 adult intensive care units from 31 hospitals were included in the study. Inclusion criteria for the hospital were; 1) with at least 500 patient days, 2) had electronic database or equivalent, and 3) conducted device-associated infection surveillance using NNIS protocols. Data were collected from the following sources; Medicare files, NNIS infection data, administrative data, AHA annual survey data, and RNs' survey. As a measurement for patient outcome, central lines associated bloodstream infections (CLBSI), ventilator associated pneumonia (VAP), and catheter-associated urinary tract infection (CAUTI), 30 day mortality, and decubiti ulcers were chosen. Descriptive statistics and multivariate logistic regression were conducted. Organizational climate was measured by a RNs' survey using the Perceptions of Nurse Work Environment scale. Similar to the previous studies' results (Aiken et al., 2002b; Needleman et al., 2002), patients with more nurse hours per patient day had lower infection and mortality. In contrast, there were mixed results for the effect of working conditions and patient outcome. It was revealed that

patients in ICUs where nurses perceived their organizational climate more positively had 19% more likely to develop CLBSI (adjusted OR: 1.19, 95%CI: 1.05-1.36, $p \leq 0.05$), whereas were less likely to develop CAUTI (adjusted OR: 0.61, 95%CI: 0.44-0.83, $p \leq 0.05$). The difference in the likelihood between developing CLBSI and CAUTI was explained by the involvement of nurses in each intervention. For example, it was suggested that CAUTI could be more nursing care sensitive rather than CLBSI. There was no significant association between RNs' perception of organizational climate and 30 day mortality. The study was conducted in ICUs at large hospitals. Thus the generalization of the result might be difficult to smaller and non ICU settings.

Another study was conducted to examine the net effect of the nurse practice environment on patient outcome and negative job outcome such as burnout, job satisfaction and intention to leave (Aiken, Clarke, Sloane, Lake and Cheney, 2008). A total of 168 adult acute care hospitals in Pennsylvania, a random sample of RNs who were practicing in Pennsylvania and 232,342 patients were included in the study. Hospitals with the following inclusion criteria were included in the study; 1) more than 100 surgical discharges, 2) structural characteristics reported in AHA annual report or equivalent, 3) sufficient survey RN respondents (average 60 RNs). The nursing practice environment was measured by three subscales from the Practice Environment Scale-Nursing Working Index (PES-NWI). A score for each subscale was calculated and the mean value of each subscale score was used for data analysis. Hospitals were categorized into 'better', 'mixed', and 'poor' environments by the number of subscales where the mean score was above the median. Patient outcomes were measured by 30 day mortality and 'failure to rescue' (defined as death within 30 days of admission among patients with complications). One in five RNs in 'poor' nurse practice environments reported that the quality of nursing care on their unit was poor or fair whereas one in 12 RNs in 'better' nursing practice environments reported the quality of nursing care was poor or fair. The odds of RNs reporting the quality of nursing care as poor or fair were lower by 38% (OR; 0.62, 95%CI:0.55-0.69, $p < 0.01$) in the 'better' and 'mixed' category hospitals compared to 'mixed' and 'poor' ('better' vs 'mixed' and 'mixed' vs 'poor'). Additionally, patients staying in the 'better' category hospitals were 14% ($1 - 0.93^2$) less likely to die within 30 days of admission compared to patients staying in 'poor' category hospitals (OR:0.93, 95%CI:0.87-0.99, $p < 0.05$).

2.3.5 Nurse Characteristics and Patient Outcomes

In addition to the relationship between nurse staffing levels and patient outcome, attention has been paid to the relationship between nursing staff attributes such as education and clinical experience and patient outcomes.

Aiken (2003) conducted a cross-sectional analysis with the data collected for the previous study (Aiken et al., 2003). She examined the association between the percentage of nurses with a bachelor's degree and patient outcome, patient mortality and 'failure to rescue' (defined as death within 30 days of admission among patients who experienced complications). Staff nurses answered a questionnaire and indicated their highest nursing education. All patient characteristics, hospital structure characteristics and nursing staffing were taken into the consideration and adjusted. Among 168 hospitals, the percentage of RNs with a bachelor's or a higher degree ranged from 0% to 70%. It was found that hospitals with a higher proportion of RNs with a bachelor or a higher degree tended to be larger, had more technology (with facilities either for open heart surgery, major organ transplantations, or both), and a lower ratio of patients per RN ($p < 0.001$). After adjusting the odds ratio, it was revealed that for every 10% increase in the proportion of RNs with a bachelor's or a higher degree, there was a decrease in the risk of mortality (OR 0.95, 95%CI, 0.91-0.99) and failure to rescue by 5% (OR 0.95, 95%CI, 0.91-0.99). On the other hand the number of experienced years as a nurse was not significant. Aiken et al (2003) provided the first empirical evidence of an association between RNs with a bachelor's degree and improved patient outcomes.

The results were supported by a more recent study by Aiken, Clarke, Sloane, Lake and Cheney, (2008) (2.3.4). It was revealed that for every 10% increase in the number of RNs with a bachelors' degree, there was a 4% decrease in patient mortality (OR: 0.96, 95%CI: 0.92-0.99, $p < 0.05$). Additionally, the likelihood of patients dying within 30 days of admission in the hospital where 60% of RNs had a degree was lower by 15% compared to patients in hospitals where 40% or less of RNs had a degree. In contrast, Van den Heede et al (2009) in their study previously discussed (2.3.3) showed no association between RNs with a bachelor's degree and patient outcomes such as 'failure to rescue', hospital mortality and hospital-acquired infections.

A Japanese study showed similar results to two studies by Aiken et al (Aiken, Clarke and Sloane, 2002a; Aiken et al., 2008). Kanai-Pak et al conducted a study to describe RNs'

burnout, job dissatisfaction and quality of care and examined their relationship to the work environment and other factors (Kanai-Pak, Aiken, Sloane and Poghosyan, 2008). A convenience sample of 19 acute care hospitals in Japan, 15 of which were university hospitals, was included in the study. Questionnaires were distributed and 5,956 RNs (response rate was 84%) completed the questionnaire. Burnout was measured by Emotional Exhaustion that is a part of Maslach's Burnout Inventory (MBI) (1983). The MBI is a standard instrument that has been used previously in many international studies (Maslach, Schaufeli and Leiter, 2001). The MBI was originally developed by Maslach and her co-worker to examine the level of burnout with people working in the area of human services such as health care providers and has been modified and revised over past decades. It is composed of three subscales; 'depersonalisation', 'emotional exhaustion', and 'personal accomplishment'. In line with standard procedures for completing this tool, RNs were asked to score each item from 1(never) to 6 (every day) (Kanai-Pak et al., 2008). The higher the total score, the higher the level of burnout. Work environment was measured by two subscales from the Nursing Work Index-Revised (NWI-R) (Lake, 2002); 'staffing resource adequacy' and 'nurse-physician relations'. RNs were asked to rate the level of agreement by 1 (strongly disagree) to 4 (strongly agree). The mean score of each subscale was calculated and the higher the score, the better the work environment. More than 60% of RNs were aged 30 or younger, and more than 70% of RNs had less than 10 years experience of which 33% of RNs had only 4 years experience or less. It was also revealed that more than half of these Japanese RNs had a high level of burnout (MBI score is above 27) and 60% were dissatisfied with their job. Additionally, more than half of these Japanese RNs reported that the quality of care was poor or fair. Regarding RNs' educational background and their perception of the quality of nursing care, RNs in hospitals with an additional 10% increase of 'inexperienced nurses', were more likely to be burned-out (OR:1.24, $p<0.05$), dissatisfied with their job (OR:1.24, $p<0.05$), and report the quality of nursing care as poor or fair (OR:1.23, $p<0.05$). However, the definition of an inexperienced nurse was not given.

2.3.6 Hospital Nursing Environment and Nurse's Job 'Outcome'

The studies discussed in the previous section were mostly based on administrative data related to nurse staffing and patient outcome. Other literature suggests that nurse staffing levels affect nurses' job satisfaction and the level of burnout and intention to leave their current job or nursing.

In a previous study, Aiken et al (2002b) (2.3.3) also examined the association between nurse staffing and burnout and job satisfaction among RNs. Burnout was Emotional Exhaustion that is a part of Maslach's Burnout Inventory (MBI) and job satisfaction was ranked from; very satisfied, satisfied, dissatisfied, and very dissatisfied. It was found that a high patient to nurse ratio was associated with high emotional exhaustion and job dissatisfaction; that is every additional patient per nurse increases burnout by 23% (OR, 1.23; 95%CI, 1.13-1.34; P, 0.01) and job dissatisfaction by 15% (OR, 1.15; 95%CI, 1.07-1.25; p<0.001). The result suggested that the lower nursing staffing level had a negative impact on nurses' well being as well as patient mortality.

A study was conducted in 65 ICUs from 22 Korean hospitals to examine the relationship between nurse staffing and the quality of patient care, job satisfaction, burnout, and RNs' intention to leave the job (Cho et al., 2009). A cross sectional design was applied including a survey with staff nurses (n=1,365). Hospitals were located in Seoul or nearby and were well-known general hospitals providing secondary or tertiary care. Two different nurse surveys were distributed; one for nurse managers (n=65) and the other for RNs (n=1365). The ICU characteristics and nurse staffing data were collected from the nurse managers' questionnaire, which asked type of ICU, number of ICU beds, and number of RNs working in each shift and etc. The questionnaire for RNs asked their perception of staff adequacy, quality of nursing care in the unit, and job satisfaction on a four point scale. Burnout was measured with nine items from the Maslach Burnout Inventory measuring Emotional Exhaustion. After adjusting for hospital, ICU and RN characteristics, it was revealed that the number of patients per RN and the perception of staff adequacy were associated with the perceived quality of patient care. RNs with a lower number of patients (2 or fewer patients) to care for were more likely to report a higher perceived quality of care compare to RNs with three or more patients to care (OR, 3.26; 95%CI, 1.14-9.31; P<0.05). RNs who perceived the staffing as adequate were more likely to report a higher quality of care (OR, 2.97; 95%CI, 2.22-3.97, p<0.05). In addition, RNs who perceived the staffing as adequate were less likely to be dissatisfied with their job (OR, 0.30; 95%CI, 0.23-0.40; p<0.05), burnout (OR, 0.50; 95%CI, 0.34-0.40; p<0.05), or leave their job (OR, 0.40; 95%CI, 0.28-0.56, p<0.05). However, no significant association was found between the number of patients per RN and job dissatisfaction, burnout, and intention to leave. The study was conducted in are particular area of Korea and this may not reflect RNs working in other units or other regions in Korea. The result implied that the same nursing staffing level (the number of patients per nurse) among the units does not give the same perception of staff adequacy among staff nurses.

Another study was conducted to examine the net effect of the nurse practice environment on negative job outcomes such as burnout, job satisfaction and intention to leave (Aiken 2008) (2.3.4). Negative job outcomes were measured by MBI, job satisfaction and their intention to leave. It was revealed that a higher portion (50.8%) of RNs reported a high level of burnout (MBI score above 27) in the 'poor' hospital category compared to the 'better' hospital category (36.3% of RNs reported high level of burnout) as well as greater job dissatisfaction (47.9% of RNs in 'poor' category hospital and 33.5% of RNs in 'better' hospital categories). After the calculation of odds ratio, it was revealed that RNs in poor/mixed work environments were more likely to be 'burnt-out' by 24% (OR: 0.76, 95%CI:0.70-0.82, $p<0.01$), be dissatisfied with their job by 25% (OR:0.75, 95%CI:0.68-0.81, $p<0.01$), and have an intention to leave within 1 year by 13% (OR:0.84, 95%CI:0.79-0.96, $p<0.01$) compared to mixed/better work environments. Thus RNs in the better work environment had a lower odds ratio of experiencing burnout, job dissatisfaction and intention to leave by 24% ($1-0.87^2$)-42 % ($1-0.74^2$).

An international comparison study was conducted to examine the effect of work environment on hospital outcomes such as nurses' burnout, job satisfaction, and the quality of nursing care (Aiken, Sloane, Clarke, Poghosyan, Cho, You, Finlayson, Kanai-Pak and Aungsuroch, 2011). A survey was conducted using a common instrument with 98,116 nurses (definition not provided in some countries) in 1,406 hospitals in 9 countries (USA, China, South Korea, Thailand, Japan, New Zealand, UK, Canada, Germany) from 1999 to 2009. The study was originally a collaborative research project including five countries (USA, England, Scotland, Canada and Germany) (Aiken, Clarke, Sloane, Sochalski, Busse, Clarke, Giovannetti, Hunt, Rafferty and Shamian, 2001). They used a common protocol in 1999 and the study was replicated in New Zealand (2004), USA (2006), Japan (2006), Thailand (2007), South Korea (2008), and China (2009). Nurses were sampled from adult acute hospitals in each country. The hospitals were sampled either; randomly from all hospitals in the region (England and Germany), or all hospitals in that region were included (Scotland, USA, Canada, New Zealand), or by a stratified sample of government regional hospital (Thailand, China, South Korea), or by a convenience sample (Japan). Nurses who were approached were all RNs in the study region, or all RNs working at the target hospitals. The work environment was measured by 28 items of PES-NWI (Lake, 2002). The median score was used rather than mean score to adjust the variation of work environment and interpretation of the items. There were four outcome variables; nurse burnout measured by Maslach Burnout Inventory, job satisfaction distinguished by four categories ;very satisfied' to 'very dissatisfied', quality of care, patients' readiness of

discharge. The results showed one third of the UK hospitals were categorized as 'better' as they scored 4-5 subscales above country's median and 28.3% of them were categorized as 'poor' as they scored 0-1 subscales above country's median. In contrast, 36.8% of Japanese hospitals were categorised as 'better' and 26.3% of them were 'poor'. However, it is difficult to simply compare as the UK data were collected in 1999 and Japanese data were collected in 2006.

Key Message and Summary

There is consistent evidence that nursing staffing level is related to the perceived quality of care as well as patient outcome (Aiken et al., 2002b; Needleman et al., 2002; Rafferty et al., 2007). Additionally, an association between nursing staffing levels and nurses' job satisfaction and the level of burnout was found. As a result of these studies, nursing staff and their working environment received an attention within healthcare settings and nurses became a key factor to deliver high quality of healthcare within the public sector (Scottish Executive, 2005a).

2.3.7 Japanese studies related to the Nursing Workforce and Patient Outcome

Despite the fact the nurse staffing levels is one of the key strategies for the Japanese government to improve the quality of nursing care (2.7.7), no Japanese study was identified from the literature search in either English and Japanese that explained this topic. Nor did the researcher find many studies by hand searches. There are only a few studies that examine the relationship between nurse staffing levels and patient outcome. However, these studies are all small and conducted in a single ward or unit.

For example, Yasukawa (2005) conducted a pilot study to examine the effect of nurse staffing levels on patient outcomes. The study was conducted with four different wards in a single hospital with 3,556 patients' data. All the data were collected from the electronic medical record. The nurse staffing level was measured by patient to nurse ratio. Patient outcomes were measured using the following indicators; patient activities of daily living (ADL), unfavourable behaviour (violence, anti-social behaviour, and low compliance), family's support, and patient's understanding of their health conditions. These factors were chosen as indicators of patient outcome because they are nurse-sensitive patient outcome that is not affected by the hospital resources or other medical interventions. The patient outcomes were indicated by 1-6 scores (higher the score, better the patient outcomes). To

minimise the influence of confounding factors, wards with patients diagnosed with similar diseases were chosen. The comparisons were made between wards and diseases. The results showed that a higher patient to nurse ratio (more patients per nurse) was likely to have lower patient outcomes on surgical wards ($L = -0.6053$, $p < 0.001$). However, the data with medical and mixed wards did not show any statistical result. It was suggested that the results were similar to Aiken et al (2002b). However, it has to be noted that this study by Yasukawa (2005) was a pilot study and conducted in a single hospital, so no generalisation of results and comparisons is possible. A common patient outcome such as mortality was not used. Additionally, the other medical professionals' staffing was not taken into consideration. It was concluded that further studies are needed to examine the nursing staffing level and patient outcome along with hospital characteristics.

2.3.8 Overall Summary

It is important to sustain the sufficient nursing workforce as the literature suggests that the quality and the quantity of nursing workforce as well as their work environment can make impact on the patient outcomes.

In the next section, the key issues with recently qualified nurses were discussed with particular focus on the situation in Scotland and Japan.

2.4 Key issues with Recently Qualified Nurses (RQNs)

RQNs have been at the centre of nursing workforce planning in Scotland and Japan (MHLW, 2005b; Scottish Executive, 2006a; Scottish Executive, 2006b). Since there are issues of an ageing population and low birth rate (General Register Office for Scotland, 2007; MHLW, 2009e) (see 2.6.2 and 2.7.2), recruiting and retaining a new generation of nurses is one of the key strategies for nursing workforce planning (Scottish Executive, 2006a; Scottish Government, 2007a; Buchan, 2008). Recent studies suggest that RQNs often feel stressed at the beginning of their career (Suzuki et al., 2006) and unprepared for clinical situations (O'Shea and Kelly, 2007). Furthermore, these situations may result in high turnover or absenteeism (Suzuki et al., 2006; Kovner, Brewer, Fairchild, Poornima, Kim and Djukic, 2007; Flinkman, Laine, Leino-Kilpi, Hasselhorn and Salanterä, 2008). For the next few sections, definition of RQNs, demographic data of RQNs, RQNs' experience and issues related to RQNs are discussed with particular focus on studies from

the UK and Japan as the pre-registration education, healthcare system and the other social factors that affect recently qualified nurses' experiences are different in each country.

2.4.1 Definition of Recently Qualified Nurses

There are many terms to describe RQNs. A nurse who has been recently registered/qualified can be described in the literature as a newly qualified nurse, new graduate nurse, new nurse, novice nurse, recent RN graduate and recently qualified nurse (Roberts et al., 2004; Suzuki et al., 2006; Clark and Holmes, 2007; Beecroft et al., 2008; Lavoie-Tremblay et al., 2008). Most of the literature did not have a clear definition for the nurse who has recently qualified. Most of the studies targeted recently qualified nurses registered or practising for 3-18 months. Thus a clear definition of nurses recently qualified was needed for this study.

In Japan, there is a commonly accepted definition of RQNs. According to the Ministry of Health, Labour and Welfare, 'Newly Graduate Registered Nurses' (NGRNs) are defined as RNs who have graduated from a pre-registration course and have no previous experience of working as a RN before the current employment. The term of NGRNs are usually used for RNs who have up to 12 months working experience.

In this literature review, for the purpose of clear understanding, 'recently qualified nurse' is used to describe the following terms; newly qualified nurse, new graduate nurse, new nurse, novice nurse, recent RN graduates.

In the following sections, pre-registration nursing education system in UK and Japan is discussed before discussing about the key issues with RQNs.

2.4.2 Pre-registration System for Recently Qualified Nurses

There have been changes in pre-registration nursing in the UK and Japan over the last two decades. The shift in pre-registration education in the UK 'Project 2000' (1989) reformed the nursing education system from a traditional 'apprentice-style' education to a diploma-level curriculum established on theoretical knowledge (Glen, 2009) and was designed to educate nurses to provide and supervise nursing care, with responsibility, analytical thinking, flexibility and the ability to recognise future requirements. 'Project 2000' was strengthened by two complementary documents, 'Making a Difference' (Department of

Health, 1999) and 'Fitness for Practice' (FFP) (United Kingdom Central Council for Nursing Midwifery and Health Visiting, 1999). FFP was a response to 'Project 2000' that had resulted in RQNs been viewed as under-skilled. FFP emphasised an early exposure of nursing students to clinical skills and aimed that the RQNs were fit for practice based on healthcare need.

In Japan, pre-registration nursing was reformed with an emphasis made on producing RNs with a high standard of quality and well equipped to meet the needs of an ageing population, and advanced medical technologies (Yoshikawa, 2003). In particular, new modules of home care and mental health nursing were established. No change was made to the required hours for clinical placement (Sasaki, 2006). Previously, many pre-registration nursing programmes were provided at a nursing training school to the diploma level. However, when some pre-registration nursing education transferred to the university level, theories and critical thinking tended to be emphasised rather than practical skills.

2.4.3 Key Issues with Recently Qualified Nurses

It has been recognised over the last few decades that RQNs experience a stressful transition period. There is a large amount of literature that explores the experiences of being a RQN and their perceptions, and discusses turnover and retention strategies. For the purpose of this study, a literature review on RQNs was conducted separately with the particular focus on the studies in the UK and Scotland, Japan, and other countries. It has to be noted that due to the nature of the topic, most literature reviewed about the experience of RQNs is qualitative. In the following sections, the key issues with RQNs are discussed broadly with an occasional focus on UK and Japanese situation.

Transition from a Student to a RN

As mentioned before, the transition period from a nursing student to a RN is challenging and stressful for RQNs. 'Reality Shock' is often used to describe the experience of being a RQN with a conflict between expectation and the reality with their new role. 'Reality Shock' was defined as 'the reactions of new workers when they find themselves in a work situation for throughout which they have spent several years preparing, and then suddenly find they are not' (Kramar, 1974). After 40 years since the first appearance of 'reality shock', there is still a large literature exploring the experience of being a RQN.

The challenges during the transition period are not specific to the UK as several difficulties are discussed in other countries regarding RQNs' first year of employment. A study was conducted in an Irish general hospital to explore how Irish RQNs perceived their role transition (Mooney, 2007). A grounded theory approach was adopted and theoretical sampling was applied. A total of 12 RQNs who were within 12 months of registration from two different cohorts were recruited. One category and three sub categories were created from the data. 'An unexpected reality' represents the unexpected challenges and issues emerging from the transition period after registration. This category was composed of three sub-categories, 'Great expectations', 'No time for nursing', and 'Facing the trepidations'. 'Great expectations' were RQNs' perceptions of the expectations of them by other health professions, patients and relatives. RQNs felt that these expectations were too high and unreasonable sometimes. 'No time for nursing' describes RQNs' perception of an expanded nursing role. 'Facing the trepidations' represents concerns and fears among RQNs after registration. RQNs reported increased and unexpected responsibilities, concerns about patients, and difficulties in implementing theory into practice. It was concluded that RQNs face difficult times and are not well prepared for the changes during transition from being a student to be a RN.

An Australian study examined the source of role stress, and changes in role stress among RQNs during two periods; 2-3 months after employment and 11-12 months after employment (Chang and Hancock, 2003). RQNs (n=110) were graduates from 13 different institutions and were working at one of four teaching hospitals in one part of Australia for 2-3 months at the time of first data collection. The questionnaire was distributed twice. Role stress was measured with eight items in two subscales, role ambiguity and role overload. The results showed that there was no significant difference during the two periods, 2-3 month and 11-12 month, for role stress ($F_{1,110}=3.23$, $p=\text{not significant}$). Factor analysis identified two factors, role ambiguity and role overload, that could explain role stress during the period of first year employment. In particular, role ambiguity was the most noticeable factor that explained 42.3% of variance in role stress among 2-3 months employed RQNs and role overload was the most important factor that explained 42.3% of variance in role stress among 11-12 months employed RQNs. Additionally, it was revealed that there was a negative correlation between job satisfaction and role ambiguity during the period of 2-3 months employment ($R=-0.37, p<0.001$) and 11-12 months employment ($R=-0.33, p<0.001$) among RQNs.

A longitudinal study conducted in the UK examined to what extent RQNs embraced the values and ideals gained from pre-registration education, to what extent they implemented their ideals and values, and if there was any gap between the theory and practice of nursing care (Maben, Latter and Clark, 2006). The study was composed of three phases. Phase 1 was a questionnaire with final year nursing students (n=72), and Phase 2 and 3 were one-off in-depth interviews with a purposive sample of RQNs (n=26) about their experience of being RQNs. Phase 1 questionnaire contained open and closed questions to identify their 'ideals' as a qualified nurse and data were analysed with content analysis. A consistent set of ideal nursing values emerged, that were; patient-centred holistic care, quality care, nursing knowledge and research based care. Phase 2 (interview at 4-6 months post qualification) and Phase 3 (interview at 11-15 months post qualification) revealed that implementing their ideals and values of nursing care was often interfered with by organisational and professional factors such as pressures and constraint of the healthcare delivery system, influence of other colleagues and their attitude towards nursing practice. It was concluded that there is a theory-practice gap in nursing and suggested that minimising the theory-practice gap might improve morale, job satisfaction and retention. The sample in phase 2 and 3 dropped down remarkably compared to Phase 1.

Higgins et al (2010) conducted a systematic literature review following the Centre of Reviews and Disseminations to analyse the experiences and perception of RQNs in the UK during their transition period from being a student to a staff nurse (Higgins, Spencer and Kane, 2010). The literature search was conducted using CINAHL and MEDLINE with the following search terms; student nurse or RQN, experience or perceptions or feelings or thoughts, and transition or transition period or change. The search focused on peer-reviewed literature published in the last 15 years, 1996-2009. Grey literature such as dissertations, conference proceedings, and reports were excluded from the review. Initially, a total of 48 articles were identified as possible articles for the review. After having read the titles and abstracts, a total of 17 articles were identified for the review. The quality of the article was examined using the critical appraisal tool developed by the Oxford University Health Research. Thematic analysis was applied to organise, analyse and present the data from the reviewed literature. Four themes emerged from the review; transition and change, personal and professional development, pre-registration education, preceptorship and support. RQNs reported the experience of change and transition from being a student to working as a staff nurse. The increased responsibility and accountability of nursing were found to be major stressors and causes for increased anxiety and pressure for RQNs. A disparity between expectations of nursing and their roles and the reality of

being able to provide the best patient care was also identified. Support and preceptorship were identified as major supports for RQNs and were found to make the transition process easier. The changes in pre-registration education, from the apprentice style to the higher education evidence based practice, was identified as an issue that related to the content of pre-registration education and how the students were to be prepared by the pre-registration education.

Unruh and Nooney (2011) conducted a study to determine RQNs' job difficulties, job demand and job control with a random sample of American RQNs, registered for 20-30 months. They examined the relationship between individual and organisational characteristics, and job difficulties, job demands and job control. 'Job difficulties' were defined as 'organisational constraints that could impede the individual's ability to perform well'. 'Job demand' was defined as 'stressors present in the work environment such as ; time pressure, heavy workload, high work pace, or difficult and mentally exacting work'. 'Job control' was defined as 'the authority for his/her own activities'. All RQNs who qualified in 2006, in Florida, USA were included in the study. A total of 414 RQNs completed the questionnaire (response rate 18%). After bias analysis (comparing the respondents to the entire RQNs in Florida), the sample was found to be representative of the whole population in Florida. It was revealed that there were relationships between individual characteristics and job difficulties. For example, older RQNs were more likely to have difficulties with organisational rules (OR: 0.98, $p \leq 0.05$) and workload (OR: 0.98, $p \leq 0.05$). In terms of organisational characteristics, RQNs with a positive perception of orientation adequacy were less likely to report job difficulties such as lack of equipment (OR: 0.82, $p \leq 0.05$), inadequate help (OR: 0.70, $p \leq 0.001$), and lack of information (OR: 0.77, $p \leq 0.01$). Regarding individual factors that relate to job demand (stressors), RQNs with a positive perception of orientation adequacy were less likely to report that they did not have time to get things done (OR: 0.82, $p < 0.05$), and working day shift, working more hours, having a higher patient load were associated with increased job demand. The study was fairly large and well conducted, but any generalisation of the results need to be done cautiously as the response rate for the questionnaire was 18% and it was conducted in only one state.

A recent study focused on RQNs starting their nursing career in ICUs (O'Kane 2012). The study was conducted in an ICU with 13 beds, at a large teaching hospital in England with eight RQNs who had been employed in ICU for 12 months or less. There were two phases; one was semi-structured interviews with RQNs and two was a focus group with seven

senior charge nurses. Four themes were emerged from the semi-structured interviews with RQNs; 'Expectations', 'Challenges', 'Preconceptions' and 'Support'. RQNs experienced several challenges during their transition process such as time management and accountability. They also emphasised the importance of support from others, such as preceptor, during their supernumerary period. Senior charge nurses were asked to comment on these themes from RQNs interviews. Despite the RQNs' anxiety of being accountable in ICU, senior charge nurses perceived RQNs' development positively in ICU, in particular they thought RQNs with previous student experience in ICU coped with the environment better than those without. Senior charge nurses expressed their concern about 'preceptor burnout' in relation to support for RQNs. They thought preceptors should be well prepared and planned in terms of allocating new nurses.

In summary, the literature suggests that the early stage of a nurse's career is challenging and stressful for RQNs (Higgins et al., 2010). Many factors within the work environment and nursing role may relate to RQNs' stress and job satisfaction (Chang and Hancock, 2003). Additionally RQNs experienced difficulties in implementing their values and ideas of nursing into clinical practice due to organisational factors. It was suggested that these challenging situations may lead to job dissatisfaction and difficulties in retention of RQNS.

Issues related to Pre-registration System and Competency among Recently Qualified Nurses

As identified (Higgins et al., 2010) the competency of RQNs is also discussed, not only in the UK, but also in Japan.

An exploratory study was conducted to capture RQNs' view on the development of competence and perception of RQNs' competence among managers and to identify the factors influencing its development (Clark and Holmes, 2007). Data were collected by focus group with a purposive sample of RQNs (n=50), experienced nurses (n=55, 11 out of 55 were practice development nurses), and individual interviews with ward managers (n=5) from three NHS Trusts in the south of England. All focus groups and interviews were conducted with a topic guide. Content analysis was applied for data analysis and six themes emerged. The findings indicated that all participants including ward managers felt that most RQNs were not ready for professional practice on registration, despite the expectations of UKCC (1986). It was thought that some time is needed for RQNs to integrate and applied into the clinical nursing after the registration. However, RQNs felt

confident and ready for professional practice by six months after registration. These findings emphasised that some time is needed for RQNs to improve their skills through experience to build up confidence post registration.

Several studies in Scotland have evaluated the curriculum built on the 'Fitness for Practice' (FFP) (Lauder, Watson, Topping, Holland, Johnson, Porter, Roxburgh and Behr, 2008b; Holland, Roxburgh, Johnson, Topping, Watson, Lauder and Porter, 2010). These papers reported findings from the National Review of Pre Registration Nursing and Midwifery Programme in Scotland (Lauder, Roxburgh, Holland, Johnson, Watson, Porter, Topping and Behr, 2008a). The Evaluation of Fitness for Practice Pre-Registration Nursing and Midwifery Curricula Project was conducted to evaluate pre-registration nursing and midwifery education and to explore the impact of FFP (UKCC 1999) and the implementation of Flying Start NHS (2.6.7). The evaluation applied multi-methods (qualitative and quantitative methods) with multi- phases. The data were collected in the following ways; systematic review, questionnaire with students (n=777, response rate was 39%), in depth interviews and focus groups with stakeholders: nursing students (n=78), mentors (n=78), practice-education facilitators (n=24), academics (n=59), senior managers (n=46), education managers (n=16), and service users and carers (n=10), and email survey with recently qualified RNs and RMs (n=97).

Phase 1 self-completion questionnaire aimed to compare the level of self-efficacy, support and self-report competency between 2004 and 2005 cohorts with a random sample of nursing students from seven different institutions in Scotland (Lauder et al., 2008b). Self-report competence was measured by Short Nursing Competencies Questionnaire (SNCQ). Self- efficacy (Confidence) was measured by the General Perceived Self-Efficacy Scale (GPSE). An originally developed scale measured the quality of support from university/college, supervisors, peers, family, and friends. The higher the score in each scale the higher the level of self-report competency, self-efficacy and support. Data were analysed with SPSS. The result showed that nursing students had relatively high levels of self-report competency (Mean: 59.81, SD:6.88, score range:18-72) , from which it was concluded that FFP met its stated objectives. No significant differences were found between cohort 2004 (Mean: 60.16, SD: 6.53) and 2005 (Mean: 59.50, SD: 7.25) (t : 1.365, $p=0.173$). Regarding the GPSE, nursing students reported relatively high levels of self-confidence (Mean: 30.67, SD: 3.42, score range: 10-40) and there was no significant difference between the 2004 cohort and 2005 cohort (U : 64318.00, $p<0.289$). Students gave support from family and friends high score (Mean: 7.46, SD1.82, score range: 0-9)

and from HEIs low (Mean: 6.15, SD: 2.03, score range 0-9). Even though it was a large study, the timing of data collection was not stated. Thus it was not clear in which year of the pre-registration course nursing students completed the questionnaire and if there was any difference in the data collection timing between the two cohorts.

Phase 2 was interviews and focus groups with the stakeholders exploring their perception on the success of FFP (Holland et al., 2010). Data were analysed with a narrative analysis approach and thematic content analysis approach. Four themes, FFP, Preparation for Practice, Being in Practice and Partnership in Practice emerged. It was concluded that RNs were perceived as fit for the practice at registration among stakeholders, which suggested that Scotland has a curriculum to meet the key recommendation of FFP (33 recommendations). On the other hand, it was pointed out that the RQNs are at the beginning of their development in their expertise and lifelong learning experiences.

In Japan, RQNs' clinical skills were also discussed as one of the key factors in the transition process and several studies were conducted to identify what kind of difficulties RQNs were facing during their nursing practice. According to a survey of RQNs (focused on RNs qualified for less than 12 months) nursing clinical skills in 2002, more than 70% of RQNs reported there were 68 commonly performed nursing care out of 103, such as securing patients' airway, that only one third of RQNs reported that they can perform comfortably. Additionally, more than 80 % of medical adverse incident involves nursing staff (RNs, RMs, ANs) and more than 30% of them were caused by medical professions including RNs with less than 3 years of experiences (MHLW, 2005b) (study details were not given and the original report was not published).

A survey conducted by the JNA in 2004 to examine the rapid turnover among RQNs (focused on only RNs qualified less than 12 months) (JNA, 2004b). The study was conducted with 1,219 hospitals and 741 RQNs (study details were not given). More than 60% of RQNs reported that lack of professional skills and knowledge, their fear of causing medical adverse incident, and lack of fundamental nursing skills were the difficulties they encountered. In particular, their fear of causing a medical adverse incident and their doubts toward their ability as a RN were identified as factor that made them think about leaving their job. Additionally, more than 50% of RQNs reported that they hoped to have more training on professional skills required in clinical practice.

Another Japanese study was conducted with 21 RQNs who graduated from one particular university and were working in five different hospitals to explore their difficulties in terms of nursing practice (Nagata, Koyama, Miki and Joboshi, 2005). Semi-structured interviews were conducted and analysed. A total of six themes were emerged from the interview data; 1) difficulties in practice due to the lack of professional knowledge, 2) risking patients' safety due to the lack of experience, knowledge and skills, 3) negative feelings towards themselves due to the incompetence, 4) communication difficulties with patients, 5) relationships with peers, 6) feeling of achievement. Japanese RQNs reported difficulties in practising fundamental nursing care such as giving an injections, taking blood, ventilator management, positioning, bed bathing. They reported the medical adverse incident caused by the lack of experiences, time and professional knowledge, and over workload. As a response to these difficulties, RQNs reported negative feelings towards their ability, patients and peers.

Similar results to the UK and Japanese studies regarding competency can be seen from a USA study that was conducted to identify the challenges and stresses among RQNs working in six different acute hospitals in Denver (Casey, Fink, Krugman and Propst, 2004). Various cohorts of RQN were asked to answer the same questionnaire which measured demographic profiles, skills and procedures which RQNs found difficult, and job satisfaction during specific timed data periods, at baseline, three months, six months, 12 months and additional follow-up. A total of 270 RQNs participated to the study (response rate 34%). The Casey-Fink Graduate Nurse Experience Survey was developed and applied to measure RQNs' experience on the entry into nursing clinical practice and during their transition period. Even though almost all RQNs felt comfortable and confident with communicating with patients and relatives, it was revealed that RQNS felt less confident with communicating with other health professionals initially, but this improved after six months to one-year period ($\chi^2=28.15$, $p=0.001$). Only 4 % of RQNs reported they could perform all 18 skills stated in the questionnaire. Seven skills such as IV skills, chest tube, central lines and blood administrations were identified as most challenging skills for 15 % of RQNs. The description of the study design and data collection was not clear.

In summary, it is common among newly registered Scottish and Japanese nurses that they have difficulties in terms of delivering nursing care. They did not feel confident at the beginning of their nursing career. In particular, Japanese RQNS reported a lack of clinical nursing skills and they had doubts about their nursing abilities.

Turnover and Retention of Recently Qualified Nurses

As a result of the challenging environment for RQNs during the early stage of their career, turnover has become another key issue among RQNs. Rapid turnover among RQNs is a shared issue among several countries including the USA (Kovner et al., 2007), Finland (Flinkman et al., 2008), Canada (Rheame, Clement and Lebel, 2011), Japan (JNA, 2004b). Turnover rate of the first year employment has been reported in USA studies ranging from 13% (Kovner et al., 2007) to 16% (Beecroft et al., 2008). Additionally, 37% of recently qualified RNs in one study reported that they planned to change their job in the near future (Kovner et al., 2007). According to the NEXT study, (Nurses' early exit study), the young age group (25-35 years old) was found to be the most eager group to leave the nursing profession (Flinkman et al., 2008). In 2010, the Japanese Nursing Association (JNA) published an annual report on the supply and demand of nursing staff in hospitals (JNA, 2010b). Turnover rate of RQNs within one-year employment has been reported at 8.6% which had decreased from 9.3% in 2005. Despite the improvement of the turnover rate of first year employed, RQNs' turnover rate ranges from 1.6% to 14.5% depending on the geographical area and it was expected among nurse managers that turnover rate among RQNs might increase in the future (JNA, 2004b).

There is a literature examining factors related to the actual turnover or intention to leave nursing profession/ their current job among RNs and RQNs. The following factors have been reported to be related to turnover among RNs; 1) burnout (Shimizu, Feng and Nagata, 2005; Estryn-Behar, Van der Heijden, Oginska, Camerino, Le Nezet, Conway, Fry and Hasselhorn, 2007), 2) job satisfaction (Gardulf, Soderstrom, Orton, Eriksson, Arnetz and Nordstrom, 2005; Kankaanranta and Rissanen, 2008), 3) organisational factors (working environment, organisational commitment)(Nogueras, 2006; Stone, Du and Gershon, 2007b; Brewer, Kovner, Greene and Cheng, 2009), 4) factors related to individual life cycle and characteristics (Hayes, O'Brien-Pallas, Duffield, Shamian, Buchan, Hughes, Spence Laschinger, North and Stone, 2006).

Several studies have examined factors related to turnover especially among RQNs or young generation of RNs and they share the similar factors, such as burnout (Suzuki et al., 2006), and job satisfaction (Roberts et al., 2004).

One study examined the relationship between job satisfaction among RQNs and their intention to leave current position (Roberts et al., 2004). A questionnaire was sent to recent

graduates from the baccalaureate nursing programme of a university located in the south eastern USA total 123 recent graduates were included in the study. Job satisfaction was measured with the McCloskey Mueller Satisfaction Scale (MMSS). MMSS are composed of 31 items in 8 subscales Lower the MMSS score indicates less satisfaction with their job. It was revealed that 21 out of 91 RQNs reported intention to leave their current position. Those who reported intention to leave had a significantly lower mean score on the MMSS compare to RQNs with intention to remain in their current job ($p < 0.001$). It has to be noted that the inclusion criteria for the sample and recent graduates were not defined clearly.

A Japanese longitudinal study conducted to investigate the factors affecting rapid turnover (Suzuki et al., 2006) and showed a similar result to Roberts et al (2004). The study was a big sample of 988 Japanese RQNs, who commenced their nursing careers in the same year as the study was undertaken, from 20 university hospitals in Japan. All university hospitals listed in the 2000-2001 hospital catalogue in Japan with more than 400 beds, excluding psychiatric wards, were included. A self-administered questionnaire was sent and six months later the employment status of those who completed and returned the questionnaire was followed. Married nurses or nurses with children were excluded because their social background is different from non-married nurses. A total of 37 RQNs had quit their job in the six month time after the questionnaire (4%). It was revealed that RQNs who had quit (13.0 ± 2.1) had a significantly higher MBI score compared to RQNs who did not quit (12.1 ± 2.3) ($p < 0.01$). Risk ratio (RR) was also calculated. The RQNs with diplomas were 10 times more likely to quit their job compared to RQNs with a degree (RR, 10.96, $p < 0.01$). There were no significant differences between RQNs who had quit and RQNs who did not quit in terms of hospital characteristics (location, department, and ward type), workload, their satisfaction with pay, the existence of reality shock, and their age. However, RQNs who had quit were more likely to be dissatisfied with their job (RR, 7.34; 95%CI, 1.47-36.62, $p < 0.01$), more likely to have the intention to leave their workplace (RR, 2.93; 95%CI, 1.34-6.40, $p < 0.01$) or nursing (RR, 2.79; 95% CI, 1.07-7.24; $p < 0.05$), and more likely to have had no support from peers (RR, 2.45; 95%CI, 1.29-4.63, $p < 0.01$). After multiple logistic regression analysis, it was revealed that the risk ratio of turnover was 2.49-6.29 time greater for with the following factors; RQNs claiming no peer support (RR, 2.49, 95%CI, 1.22-5.08; $p < 0.01$) RQNs with dissatisfaction with their ward assignment (RR, 3.36; 95%CI, 1.62-6.95; $p < 0.01$), and RQNs with diploma (RR, 6.29; 95%CI, 2.19-18.06; $p < 0.01$). A follow up study conducted in 2008 also supported the result (Suzuki, Itomine, Saito, Katsuki and Sato, 2008).

Recent work provided a different view of RQNs' retention. A Canadian study was conducted to examine RQNs' intention to leave their current position and identify the relationship between transition programmes, empowerment, and work environment to their intention to leave (Rheume et al., 2011). All new graduate nurses were included in the study over five years from one provincial nursing regulatory body. A questionnaire was distributed to RNs who graduated the previous year to data collection and 349 RQNs completed the questionnaire (response rate was 27%). RQNs who were practising for 12-16 months at the springtime of each year were included in the study. A questionnaire contains the following sections; employment status, work environment, orientation programme, mentorships programme, empowerment, RQNs' intention to leave and demographics. It was revealed that there is variation in the length of orientation programme ranging from two days to over 10 days and most of RQNs (69%) agreed that the orientation programme was helpful. Regarding the mentorship programme, the length of mentorship programme varies from 1-2 months to 7 months. Most of the RQNs had employer-based mentorship programme. Half of the RQNs reported that they have thought about leaving their job, 5% of those showed their intention to leave their current job. Additionally, it was revealed that there is negative correlation between perception of their work environment and intention to leave ($r=-0.37$, $p\leq 0.001$).

Key Message and Summary

In summary, literature described that RQNs' experiences are stressful and challenging (Chang and Hancock, 2003; Mooney, 2007; Higgins et al., 2010; Unruh and Nooney, 2011). Several individual and organisational factors are related to stressful and challenging experiences, such as work environment (Rheume et al., 2011; Unruh and Nooney, 2011). RQNs also revealed that they had difficulties in implementing their values and idea into clinical setting (Maben et al., 2006). A previous study reported that RQNs felt that they are not ready for practice and they were perceived so by ward managers (Clark and Holmes, 2007). As a result of these difficult situations for RQNs, high turnover rate among RQNs became issues in the several developed countries (Suzuki et al., 2006; Kovner et al., 2007). There is evidence that support that RQNs' work environment, job satisfaction and work environment are keys for the RQNs retention (Suzuki et al., 2008; Rheume et al., 2011).

In the next section, the background of Scotland and Japan such as the healthcare system and nursing are described to give a broad understanding of the context of this study. Later

in the each section for Scotland and Japan, policies related to RQNs are discussed to address the issues of RQNs in each country.

2.5 Nursing Workforce Policies and Nurses' Involvement in Policies

As the importance of sustaining the sufficient nursing workforce was emphasised in the previous sections (2.3), it is critical for government and healthcare organisations to develop and implement strategies to promote the stability of nursing workforce. One of the main drive of these attempt is the issue of shortage in nursing (MHLW, 2005a; Buchan and Calman, 2006), not only about the numbers, but also how the nursing workforce should play their role and ability effectively in the healthcare system (Rafferty et al., 2007). In the following sections nursing workforce policy in the UK and Japan are briefly described and the involvement of nurses in policies and implementation is discussed.

2.5.1 Nursing Workforce Policy in UK and Japan

Nursing workforce policies need to be established based on valid and reliable data (Attree, Flinkman, Howley, Lakanmaa, Lima-Basto and Uhrenfeldt, 2011). However, it is a challenging task as there is no universal, standardised definition, measure or methodology for nursing workload (Attree et al., 2011). Workforce planning should be performed in each level, from national to local level. Buchan (2006) suggested four areas for policy intervention to sustain the nursing workforce; 1) Workforce Planning, 2) Retention and Recruitment, 3) Deployment and Performance, 4) Utilisation and Skill Mix. It was suggested that there is a need to develop an appropriate workforce planning mechanism to monitor supply and demand, which should reflect the demographic and health need of the patients and the profile of workforce. The involvement of all stakeholders in workforce planning was highlighted (Buchan, 2006). Additionally, there is a need, not only for improving retention and recruitment by promoting favourable workplace environment, but also for attracting new nurses and returners by adding more value on nursing career, such as flexible working hours and other incentives. Deployment could be a short-term solution for matching the workload and staffing. Buchan argued there is a need to develop flexible work patterns and effective management system. Skill mix was one of the key challenging for management as there was still little literature on skill mix.

UK nursing workforce policies reflect these four elements. A policy review among five European countries (Denmark, Finland, Ireland, Portugal, and UK) was conducted to

analyse nursing workforce policies and to identify and share solutions and improve evidence-based workforce policy development (Attree et al., 2011). The nursing workforce policies were analysed thematically using content analysis. Key themes from the policies in five countries were included; increasing recruitment and retention, improving nurses' practice environment and working lives, deployment and skill mix. These themes were similar to Buchan's four nursing workforce policy areas. The nursing workforce policy in UK was analysed and concluded that the principles of the policies included improving retention and recruitment by improving work, pay and conditions (Department of Health, 2004a). These improvements were achieved by improved work environment, management and leadership, and providing support and education to the staff so that they could perform well and develop knowledge and skills.

Japanese nursing workforce policies reflect most of the four elements. There are three major strategies for Japanese government in order to sustain and improve the nursing workforce (MHLW, 2010c). Firstly, ensuring a certain number of new entrants to nursing by supporting the nursing schools financially. Secondly, improving retention by improving work environment, introducing flexible work hours, and improving the quality of post-registration training. Finally, attracting returners into nursing practice.

Detailed description of policies related to recently qualified nurses, including government health policies are given in 2.6.7 and 2.7.7.

2.5.2 Nurses' Involvement in Policy and Implementation

The contribution of nurse professionals to health policy development and the implementation process is crucial (International Council of Nurse, 2001; Hewison, 2007) as nurses are usually the group closest to health service consumers and their families. Toofany (2005) argues that health policy should be understood by nurses who are in the front line of delivering direct care to the patients. Nurses work in situations where there are often financial restraints and political change (International Council of Nurse, 2001). The current environment for health service providers including nurse professionals is often in conflict with financial restraint and increased demand for delivering better health care to the public (2.6.4 and 2.7.4). The nurse plays a key [pivotal] role in providing direct patient care. Many health policies have a significant impact on the nursing workforce. It is therefore important that nurses respond to government health policies so that they can contribute to achieving the goals of government policies and initiatives.

Although the importance of nurses' involvement in policy has been underlined (Toofany, 2005), Buchan and Evans (2008) state that there is little literature on the view of nurses towards policy implementation and the impact of such policies on nurses. There are only few surveys conducted by professional unions to examine the impact of legislative change in Japan (JNA, 2007c). Their participants were Directors of Nursing, not ward managers or registered nurses on the ward.

In 2002, a survey was conducted with 5,693 nursing staff (Response rate 58.65%) in 54 medical institutions in Japan to examine nursing staff's perception and their interests in policies related to nursing practice (Hisatsune, 2002). Most of the participants (93.5%) were working in hospitals and 85.0% of them were registered nurses, and 16.7% of them in managerial positions. It was revealed that more than 80% of the participants had an interest in policies related to healthcare and nursing practice, and older nursing staff were more likely to have interest in policies ($F=235.5$, $p<0.001$). However, more than one third of nursing staff stated that they were not interested in the policy making process and 80% of all participants did not know any background of the previous legislation change in nurse staffing level in 2001, of whom 47.9% believed that policies would not be affected by us and half said they did not know anything about the policy making process or policies. This result showed that there was a gap between the nursing staff's interest in policies related to healthcare and nursing practice and the actual policy developing process.

Several other factors have been suggested as factors in terms of implementing changes in healthcare service. A comparative case study was conducted in three hospital trusts in England to analyse influencing factors in the process of policy changes (Fulop, Walters, Perri and Spurgeon, 2012). Semi-structured interviews were conducted with internal and external stakeholders, such as the Director of Nursing, Financial Manager, Local Media and Member of Parliament. Several factors were suggested as influence factor of the process and the result of policy change; drivers of change, the content of change, financial pressure, influence of stakeholders and management approaches to the change. Overall, the involvement of nurses in policy developing and implementing process was highlighted in the literature as well as other important factors in order to implementing the policy changes.

2.6 Scotland

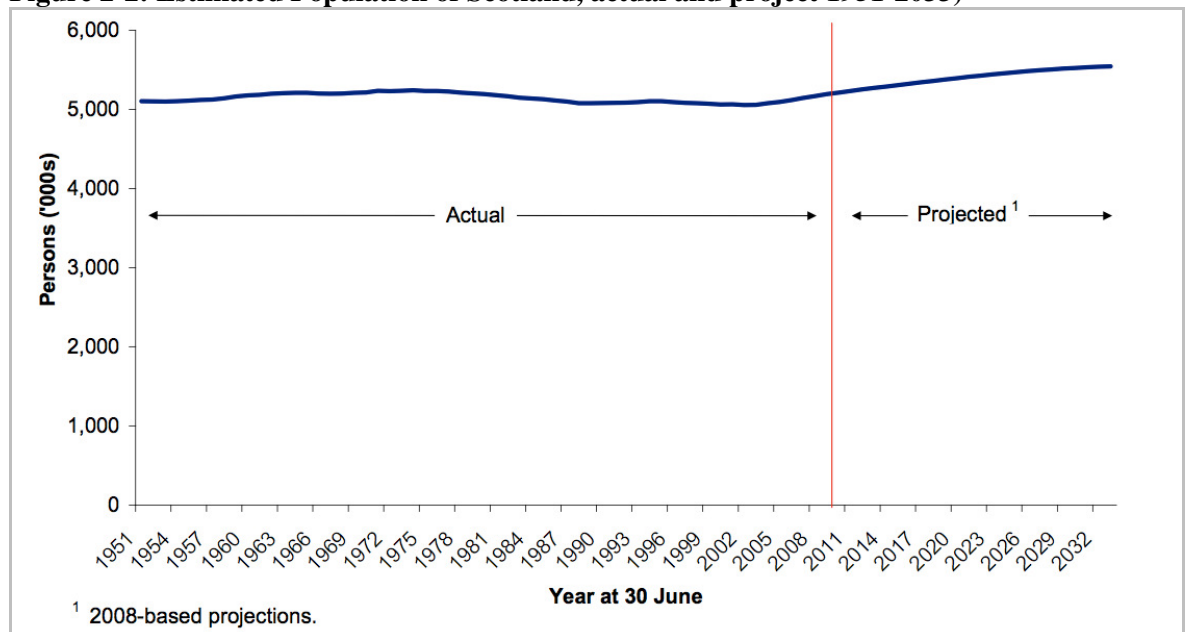
2.6.1 Introduction

In this section, the background of Scotland such as the healthcare system and nursing are described to give a broad understanding of the context of this.

2.6.2 Geography and Sociodemography

Scotland occupies the northern part of Great Britain and is a country of the United Kingdom. According to the Mid-2009 Population Estimates Scotland (2010), the estimated population in Scotland is 5,194,000, the highest population since 1979 (General Register Office for Scotland, 2010a). Over the last 50 years, the population in Scotland has been stable, even though for the last 10 years, the Scottish population increased by 2.4 % from 5.06 million to 5.19 million. Between 2008-2009, it grew by around 25,500 (General Register Office for Scotland, 2010b). This recent population increase is explained by increased in net migration, and births exceeding death. Figure 2-2 shows the trend of the population in Scotland and projected changes for the next 20 years. The latest projection suggests that the population of Scotland will increase to 5.54 million by 2033 (General Register Office for Scotland, 2009).

Figure 2-2: Estimated Population of Scotland, actual and project 1951-2033)

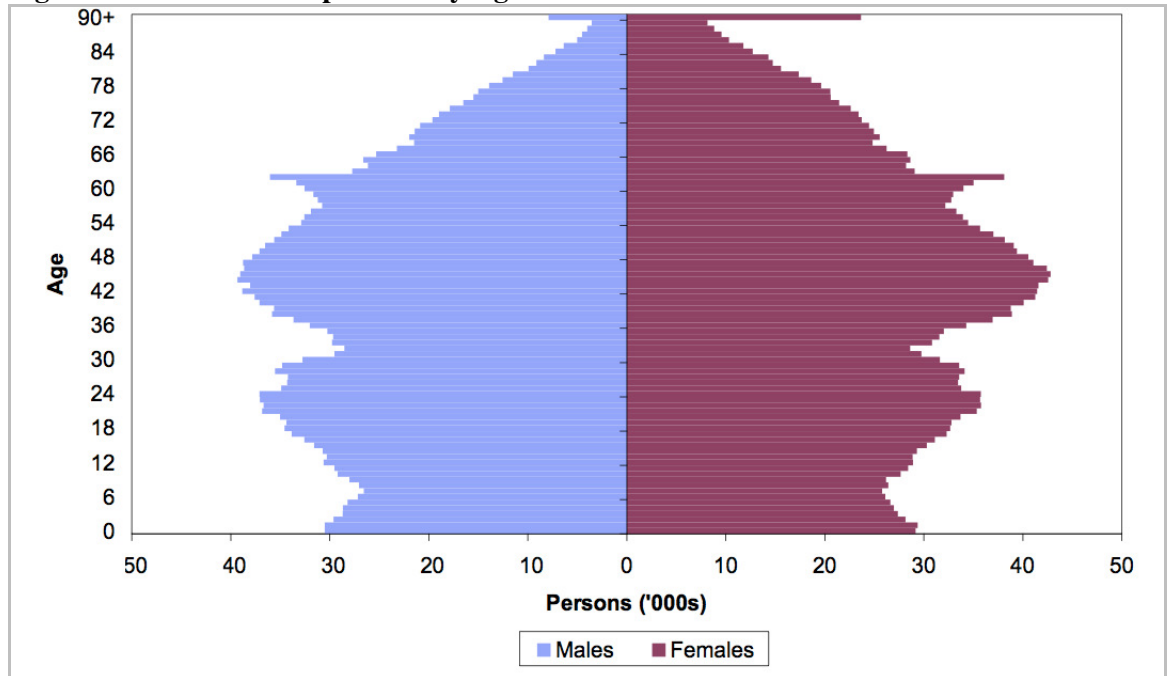


Source: Reproduced from General Register Office for Scotland (2010)

Figure 2-3 shows the structure of population by age group. Scotland's population is composed of 18 % aged under 16 years, 63% working age people (16-59 for women, 16-64

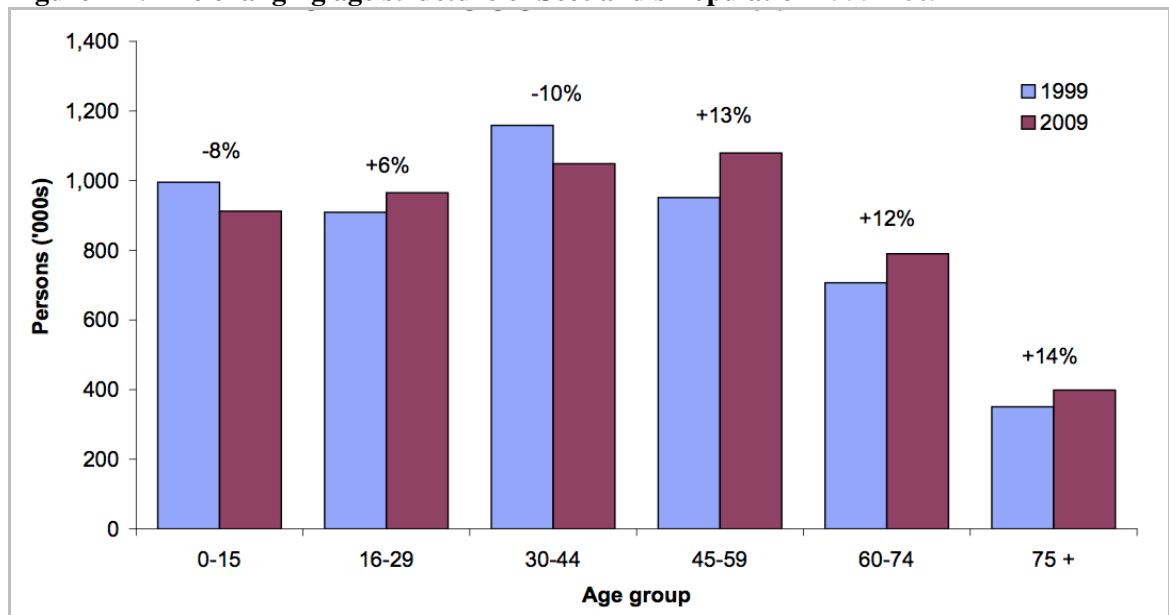
for men), and 20% pensionable age (over 60 for women, over 65 for men). The sharp peak of age 61 years is the result of the 1947 'baby boom' in 1947 with a second 'baby boom' bulge around 35-50. The other age bulge age around 15-30 is composed of children of the baby boomers.

Figure 2-3: Estimated Population by Age and Sex 2009



Source: Reproduced from General Register Office for Scotland (2010)

Scotland has an ageing population like other developed countries as seen in Figure 2-4. For the last 10 years, while the population has been growing, the population aged under 16 has decreased, but the population aged over 45 years has increased, especially, in those aged over 75 years. It is also projected that the number of people aged over 60 will increase by 50 % by 2033 (General Register Office for Scotland, 2010a).

Figure 2-4: The changing age structure of Scotland's Population 1999-2009

Source: Reproduced from General Register Office for Scotland (2010)

Mortality in Scotland improved over the last few decades. Firstly, the average age at death has increased from 76 years to over 80 years old (General Register Office for Scotland, 2010b). The mortality among certain age groups has also improved dramatically compared to 1981. Mortality has decreased by 43-49 % in the 65-74 age group and by 19-33% in the 75 and over. Inequality in health among socioeconomic groups has been an issue in Scotland (General Register Office for Scotland, 2010b). Interestingly, mortality varies by area in Scotland after taking differences in the population structure into consideration. In Glasgow, mortality is 27 % higher than the Scottish average, which is 17% higher than the UK average. Similarly to mortality, there are considerable differences for life expectancy between areas. Life expectancy in Scotland improved over the last 25 years, increasing from 69.1 for men and 75.4 for women to 75.3 for men and 85.2 for women during 1981-2008. However, the difference in life expectancy is 5.3-7.3 years between Glasgow City (lowest) and East Dunbartonshire (highest).

2.6.3 Economies and Political Status

The United Kingdom of Great Britain and Northern Ireland (UK) is a constitutional monarchy and sovereign state with four countries, England, Wales, Scotland and Northern Ireland. These countries have devolved national administrations with varying powers. Scotland has a separate legal and educational system. A devolved Scottish parliament was established in 1999 following a referendum in 1997. The UK parliament still retains some powers in some areas such as Foreign Affairs, Defence and National Security, and Social

Security. ‘The Scottish Executive’ was officially re-named after the election in 2005 to the ‘Scottish Government’¹².

The UK’s Gross Domestic Product (GDP) has increased by 46% for the last 20 years from USA \$1,012 billion to USA \$2174 billion US dollars, and is ranked 6th in the world (World Bank, 2009). Until 2008, the UK GDP had annual growth 1-3%. In 2009, annual growth dropped to -5% due to the global recession.

The unemployment rate in February 2011 was 7.8%, almost the same as the rate in 2009 (Office for National Statistics, 2011). In the early 2000s, the unemployment rate was around 4-5%. After the recession it increased to 7-8%. In Scotland, the unemployment rate was generally lower than elsewhere in the UK until February 2010.

2.6.4 Health Care System in Scotland

In this section, the health care system in Scotland in the context of the UK is briefly discussed to provide understanding of the context of National Health Service (NHS) and as background for issues in the nursing workforce.

Overview of National Health Care System of Scotland

The health service in Scotland was established in 1948. The National Health Service Act 1948 (repealed by the National Health Service Act Scotland 1978) provided free preventative and curative healthcare service to all ‘ordinary residents’ in Scotland (European Observatory on Health Care Systems, 1999). The NHS in Scotland has a duty to promote a comprehensive and integrated health service to improve health, prevent, diagnose, and treat illness (UK Legislation, 1978; NHS Scotland, 2011). NHS Scotland, as it is called now, is financed by general taxation and National Insurance Contribution. NHS Scotland has 14 boards that are geographically based and eight other special boards with special functions (e.g.; the NHS National Service Scotland, NHS24, NHS Education for Scotland) (NHS Scotland, 2011). Each NHS board has responsibility for planning and providing care efficiently and effectively for the people in that area. NHS Scotland is governed by the Scottish Government’s Health and Wellbeing Directorate, which is responsible for setting policies on the NHS Scotland, public health, adult social care and

¹ <http://www.scotland.gov.uk/About/>

² <http://news.bbc.co.uk/1/hi/scotland/6974798.stm>

other related areas. Responsibility for nursing is located at policy level within Health, Wellbeing and Cities Strategy and Health and Social Care Directorates and the Chief Nursing Officer, Ros Moore (December 2011).

Delivery of Health Care

The primary care system in the UK has a ‘gate keeping’ role (European Observatory on Health Care Systems, 1999) and is usually provided by self-employed General Practitioners (GP) with contractual engagement to the NHS Scotland. The first contact for general medical needs is done with GPs and associated staff (e.g. practice nurses and community nurses). Patients need to register with a GP to obtain any healthcare service from NHS Scotland³. Patients may choose their GP, but choice can be limited by geographical area. GPs provide preventative, diagnostic curative primary care services. In 2010, there were 4,960 GPs in Scotland (iSD Scotland National Statistics, 2010c) and 34,101 GPs in the UK (British Medical Association, 2010).

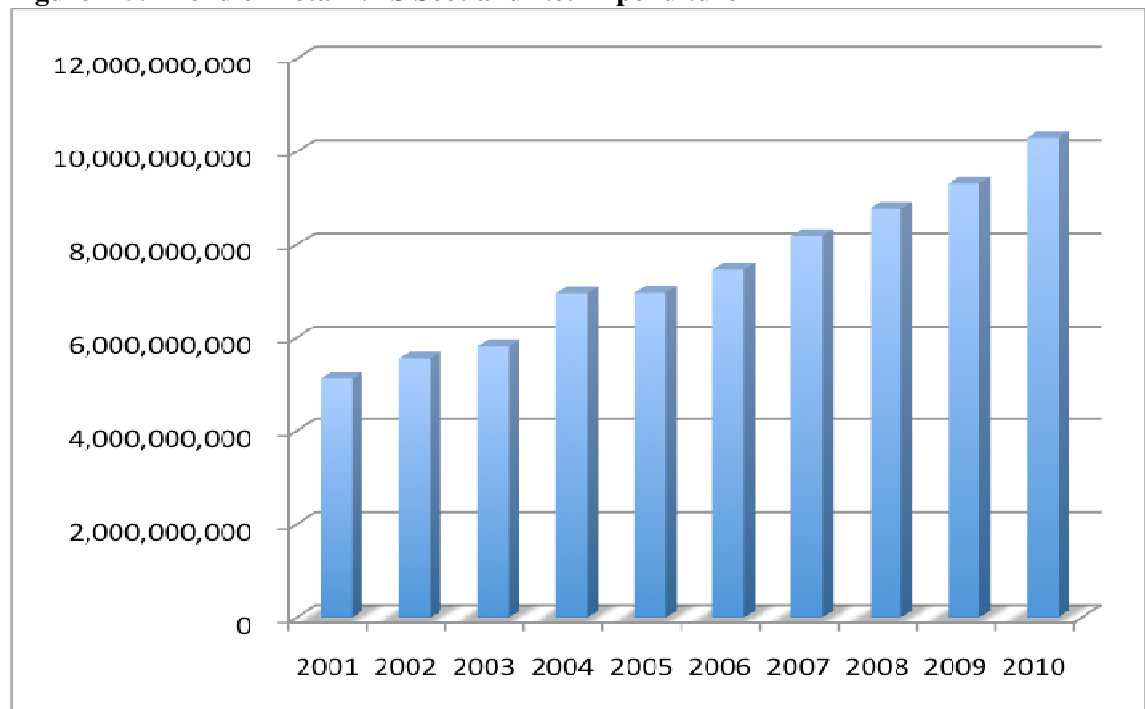
NHS funded secondary care is provided by salaried specialist doctors and NMAHPs (Nurses, Midwives, Allied Health Professionals) working in NHS hospitals. When patients need more specialised care, GPs refer patients to secondary care. Unlike other countries (Japan see 2.7.3), UK patients do not have direct access to specialist other than emergency situation (European Observatory on Health Care Systems, 1999).

In the UK, around 12% of healthcare expenditure is covered by the private insurance and private expenditure which are directly from the household (OECD, 2011).

Finance of Health Care System

As mentioned before, general taxation and National Insurance Contributions finance the NHS healthcare service. Figure 2-5 shows the constant increase of NHS Scotland expenditure between 2001 -2010 where it almost doubled. The latest report showed health expenditure was more than UK £ 10 billion in 2010 (iSD Scotland National Statistics, 2010b).

³ <http://www.psd.scot.nhs.uk/doctors/registration-with-a-practice.html>

Figure 2-5: Trend of Total NHS Scotland Net Expenditure

Source: Original diagram, compiled from information in iSD (2001-2010, available on the website⁴)

The public sector across the UK is having financially difficult times due to the economic recession and will be facing more challenges as the UK budget reduces (Buchan and Seccombe, 2009). In 2009-10, Scottish Government received UK £33 billion to spend on health, education and policing, transport and housing. However, the total spending is to be cut over the period to 2014-2015 by 11%. The Scottish Government (2010) noted that the cuts will last at least with the next decade in order to recover to the same level as 2009-2010 (Scottish Government, 2010b). There will be an additional UK £280 million to run NHS Scotland in 2011-12 in order to minimise the impact of the cut in NHS Scotland.

However, health profession unions reported the possible impact on the NHS Scotland as NHS Boards were facing financial pressure (Royal College of Nursing Scotland, 2010). These financial difficulties resulted in the intention to reduce the number of nursing and midwifery staff in each Health Board. According to the report, many Health Boards intend to change the proportions of RNs to non-registered nursing staff. The report warned of the possibility of a negative impact on patient care due to the potential reduction of RNs.

⁴ <http://www.isdscotland.org/Health-Topics/Finance/Costs/costs-archive.asp>

2.6.5 Nursing in Scotland

In this section, a brief history of UK nursing and nurse education is provided as background in order to discuss issues related to the nursing workforce in Scotland.

The UK Nursing System and its History

Table 2-3 shows a brief history of UK nursing. Florence Nightingale established the foundation of modern nursing in the UK in 1860, with a nursing school at St Thomas' Hospital in London (Bostridge, 2008). When state registration of the medical profession was introduced in 1858, observers pointed out the necessity of a registration system for nursing (Nursing and Midwifery Council, 2010b). Following the establishment of the first organised nurse training in 1860, support for the regulation of nursing started to spread widely. By the 1880s, there were two voluntary registration systems for nurses established by different groups, the Hospital Association and the British Nursing Association (Nursing and Midwifery Council, 2010b). The former was purely administrative and the latter was for public protection. During the 1890s, there was a growing pressure to establish state registration for nurses. However, this failed several times due to disagreements within the professions over the registration system and a lack of support from Parliament. The Midwives Registration Act (1902) was established and the state regulation of midwives was introduced in 1902. The College of Nursing (now the Royal College of Nursing) was established in 1916. More than a decade later than the Midwifery Registration Act, the Nurses Registration Act was passed in 1919 for England/Wales, Scotland and Ireland after the significant contribution of nurses during the World War I and the increased contribution of women generally in society⁵.

In 1979, the Nurses, Midwives and Health Visitors Act was introduced based on the Briggs Report (1972). Briggs made a number of recommendations for nursing education and the regulatory structure; in particular a unified central council and separate board was established in each of the four countries with responsibilities for nursing education (Nursing and Midwifery Council, 2010b). As a response to the Briggs Report, the United Kingdom Central Council for Nursing, Midwifery and Health Visitor (UKCC) was formed in 1983. The UKCC was responsible for maintaining a register of UK nurses, midwives and health visitors, providing guidance to registrants and handling professional misconduct complaints (Nursing and Midwifery Council, 2010b). National Boards were also

⁵ <http://www.nmc-uk.org/About-us/The-history-of-nursing-and-midwifery-regulation/>

established for each UK country to monitor the quality of nursing and midwifery education courses. In 2002, the Nursing and Midwifery Council (NMC) was established taking on these functions from the UKCC and the UKCC was discontinued⁶.

Table 2-3: Brief History of UK Nursing

Year	Principal Legislation	Other Important Events
1858	State registration of Medical Professions	
1860		First organised nurse training introduced
1902	Midwifery Registration Act	
1916		Establishment of the College of Nursing (Current Royal College of Nursing)
1919	Nurse Registration Act	
1948		NHS launched
1972		The Briggs Report was published. It recommended number of changes in nursing education
1979	The Nurses, Midwives and Health Visitors Act	
1983		Establishment of the UKCC
2002		Establishment of the NMC

Becoming a registered nurse in the UK⁷

In order to practise nursing in the UK, registration with the NMC is necessary. To register with the NMC, students have to complete a three year diploma (only until 2013) (Nursing and Midwifery Council, 2010a) or a degree course that meets the standard of proficiency for pre-registration nursing education (Nursing and Midwifery Council, 2010a). Pre-registration nurse education in the UK is funded by the government as a part of the government's approach to increasing the nursing workforce (UK Legislation, 2007; Buchan and Seccombe, 2009). The policy and the funding for pre-registration nurse education are related to each other in order to control and predict the entry to nursing through how much funding is allocated to pre-registration nurse education. Courses should be 50% theory and 50% nursing practice. Ten universities in Scotland provide pre-registration education and students are educated at either diploma or degree level. Clinical practice is provided by the NHS and other organisations. Nursing is divided into four branches; adult nursing, children's nursing; mental health nursing and learning disabilities nursing. This thesis addresses adult nursing only.

⁶ <http://www.nmc-uk.org/About-us/The-history-of-nursing-and-midwifery-regulation/>

⁷ <http://www.rcn.org.uk/nursing/becomenurse>

2.6.6 The Nursing Workforce in Scotland

In this section the key issues related to Scottish nursing study are discussed. The key issues in Japanese Nursing workforce are discussed later in this chapter (see 2.7.6). The reason why the key issues are discussed separately is that the key issues related to nursing workforce are different in each country. Currently nursing is facing a number of challenges and most of them are shared among developed countries (Simoens, Villeneuve and Hurst, 2005). For example the shortage of nursing has been a global issue for the last two decades (Finlayson, Dixon, Meadows and Blair, 2002; MHLW, 2005a; Ross, Polsky and Sochalski, 2005; Buchan, 2006; Buchan and Calman, 2006). There is a large literature discussing these challenges in nursing, and giving recommendations and strategies to improve the current situation (Oulton, 2006). However, there are other major issues related to nursing workforce planning, nursing education and nursing practice. Specifically, nursing workforce planning, retention and recruitment are acknowledged as the biggest challenges among developed countries (Simoens et al., 2005). Furthermore, a shortage of nursing staff has been reported in most OECD countries (Simoens et al., 2005). It has been predicted that the shortage of nursing staff could continue, or even deteriorate in the future due to the ageing profile of the nursing workforce, particularly if an appropriate policy response is not developed (Simoens et al., 2005). The next few paragraphs highlight the current situation in Scotland in the context of issues and challenges related to nursing workforce, policies.

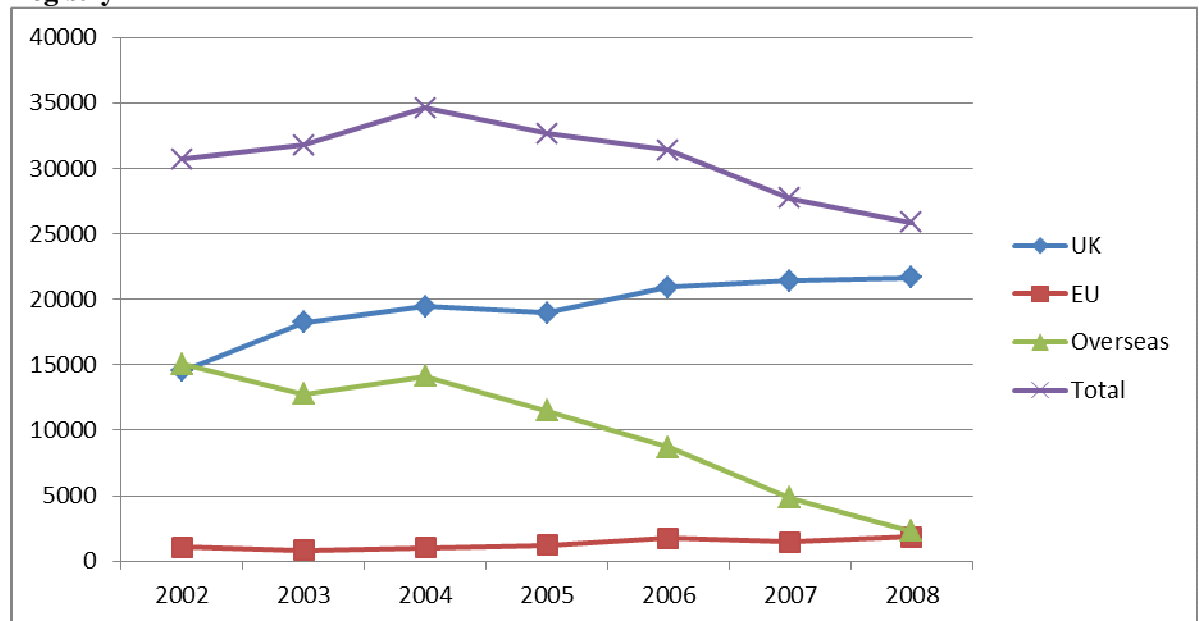
Demographic data on nurses: How many nurses are there?

According to the Nursing and Midwifery Council (NMC) 2008 statistics (Figure 2-6), the total number of RNs and midwives has increased over the last ten years; that is 676,547 nurses and midwives were registered with the NMC in March 2008, an increase from 637,449 in 1998. This growth can be explained by government investment in international recruiting, increased funding in nurse education and policies targeted at the retention of current staff and recruitment of returners (Buchan and Seccombe, 2009). During the period 1998 to 2008, there was a constant increase in new, UK registered nurses to the NMC Register because of increased government funding for pre-registration places (Buchan and Seccombe, 2009). In 2006, new registered nurses from UK education exceeded 20,000 and increased up to 21,661 in 2008 (Nursing and Midwifery Council, 2008).

There was a dramatic decrease in international recruitment. Whereas the number of international nurses increased during the late 1990s to the early 2000s, peaking in 2002, due to a policy change (Nursing and Midwifery Council, 2008), it became more difficult for international nurses to enter the UK. Thus the number of international RNs significantly decreased in the last five years (Buchan and Seccombe, 2009).

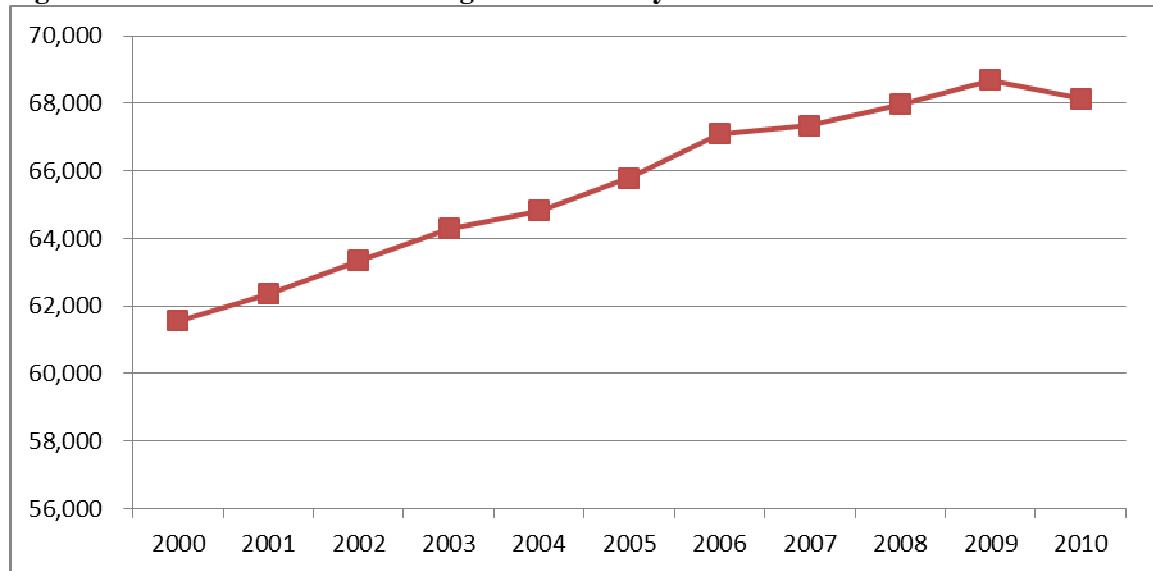
Even though there has been a consistent increase in the number of registered nurses and midwives (RMs) at the NMC, the number of registered nurses and midwives declined by 10,339 in 2008 (Nursing and Midwifery Council, 2008). A reduction in the number of initial registrations and an increased number of RNs leaving the profession were considered as explanations for this drop in the number of registrations (Buchan and Seccombe, 2009). The total number of RNs and RMs in Scotland also showed a similar path as the UK during 2002-2008. According to NMC statistics (Nursing and Midwifery Council, 2008), a total of 25,864 registered nurses were registered in 2008 of which a total of 2,519 were registered in Scotland.

Figure 2-6: Total Number of New (UK) and Additional (EU and others) Nurse Entering UK Registry



Source: Original diagram, compiled from information in NMC (2008 and Royal College of Nursing 2009)

Until recently, Scotland has seen a continuous growth in the total number of nursing staff (RNs, RMs, and other support nursing staff) working in the NHS (see Figure 2-7). In 2000, 61,560 nursing staff were working within NHS Scotland and that number increased by 11.5% up to 68,681 in 2009. However, it has to be noted that the number dropped 0.8% in 2010 to 68,133 (iSD Scotland National Statistics, 2010d).

Figure 2-7: Total Number of Nursing and Midwifery Staff in NHS Scotland

Source: Original diagram, compiled from information in Scotland iSD Scotland (2010)⁸

In Scotland, the vacancy rate for registered nurses and midwives in NHS Scotland did not change between 2008-2010⁹(iSD Scotland National Statistics, 2010a). However the actual number of vacant posts for nurses and midwives increased (Whole time equivalent adjusts headcount staff figures to take account of part time staff, thus the number includes decimals). Vacancy posts were 1,471.5 (2.5%) in 2008 and 1,476.3 (2.5%) in 2009 (iSD Scotland National Statistics, 2010a). The number dropped in 2010 to 494.6 (0.9%) due to frozen posts. Among all staff in NHS Scotland, the turnover rate (all NHS staff leaving NHS Scotland) was 8.8% in 2009, decreased from 10.8% in 2008. Nursing and Midwifery staff turnover in 2009 was 7.8% (Royal College of Nursing Scotland, 2010). On the other hand, in the NHS Scotland survey in 2010, only 18 % of nursing and midwifery staff reported that there was enough staff for them to do their job properly and most of them reported unrealistic time pressure.

In summary until recently the number of nursing and midwifery registrations in Scotland gradually increased in the last decade as well as the number of nursing and midwifery staff working in NHS Scotland. Figure 2-6 shows the response to policy change and financial situation in UK (2.6.4). It can be seen that the policy and government financial situation have had an impact on the numbers of nursing post with in NHS.

⁸ http://www.isdscotlandarchive.scot.nhs.uk/isd/5352.html#staff_in_post

⁹ <http://www.isdscotlandarchive.scot.nhs.uk/isd/5352.html#vacancies>

International Recruitment

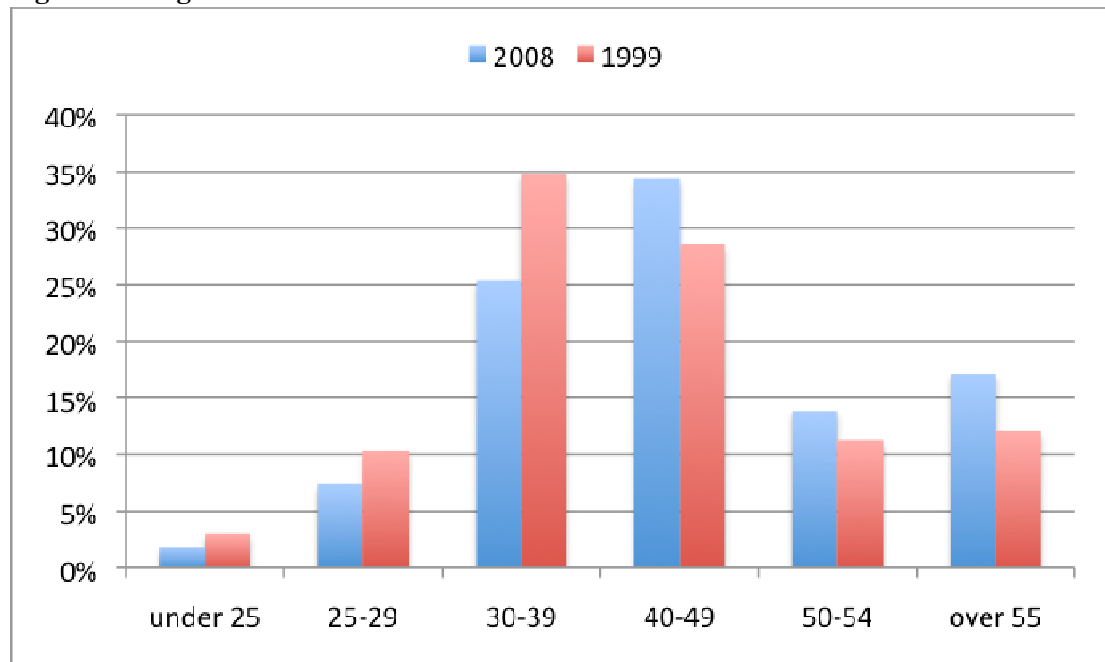
As stated previously, international recruitment played an important role during the late 1990s to early 2000s. Arguably, international recruitment attracted policy makers because it was a quick fix that recruited nurses without extra expenses. When the Labour Government took power in the United Kingdom in 1997, the government committed to an increase NHS staffing as a response to the Wanless report (2001) (Wanless, 2001). The UK government set out the goal of an increase of 20,000 more RNs, 7,500 extra consultants and 2,000 more general practitioners by 2004. These targets were met within the time frame through improved retention (e.g. flexible working), an increased number of RNs in training and international recruitment (Buchan and Seccombe, 2009) and international recruitment was a key response to a policy of increasing the number of NHS health professionals.

Since the change in NMC regulations for overseas trained nurses and the government changes in policy on international recruitment during 2006-2008, it has become more difficult for non-EU nurses to enter UK nursing. As the international recruitment of nurses is no longer government policy, it is important to retain the intake of a new generation into nursing as well as retaining experienced RNs to maintain and develop the nursing workforce (Buchan and Seccombe, 2009).

The Ageing Workforce

Demographic changes, especially an ageing population (2.6.2) are acknowledged as significant challenges as they affect the nursing workforce in two ways. The first concern is that an ageing population is likely to increase the demand for nursing (Scottish Government, 2010a). For example prolonged life expectancy and advanced medical technology have made an impact on a range of patient conditions. This means there will be more aged patients with chronic conditions who need more nursing and medical interventions (Scottish Government, 2010a).

The second concern is that the nursing workforce itself is ageing across many developed countries such as USA and Canada (Goodin, 2003; Buchan, 2008; Jackson, 2008). Figure 2-8 shows the age profile of RNs in the UK 1999 and 2008. The figure clearly shows the shift of age profile over the last ten years among UK RNs.

Figure 2-8: Age Profile of RNs with NMC in the UK 1999 and 2008

Source: Redrawn from NMC Statistics¹⁰ (2008)

In 2008, less than 10% of RNs were aged under 30 years whereas more than 30% of RNs were aged over 50 years (n=200,000) (Nursing and Midwifery Council, 2008). Over the next decade, it is estimated that there will be a shortfall in the registered nursing workforce population because of the number of RNs retiring (Buchan, 2008). However there is a possibility that the recession may have some impact on retirement behaviour among older RNs who may delay retirement (Buchan, 2008). The fact that one third of RNs are aged over 50 years challenges the government to respond in terms of retention and recruitment of RNs (Buchan, 2008).

Attracting new people is crucial to maintaining and developing the nursing workforce. There is a concern about recruiting new people into nursing (Buchan and Seccombe, 2009) even though the application for nursing degrees has increased by 40-50% in 2011¹¹. Additionally, it has been argued that the shift of nursing pre-registration education to the degree level might result in losing potential candidates for RNs (Buchan and Seccombe, 2009) (by 2013, all pre-registration in UK will be educated at degree level¹²).

¹⁰ <http://www.nmc-uk.org/About-us/Statistics/Statistics-about-nurses-and-midwives/>

¹¹ http://www.ucas.ac.uk/about_us/media_enquiries/media_releases/2011/20110531

¹² <http://www.nmc-uk.org/Get-involved/Consultations/Past-consultations/By-year/Pre-registration-nursing-education-Phase-2/Nurse-education-Now-and-in-the-future/>

The Impact of the Financial Crisis on the Nursing Workforce

As mentioned before (2.6.4), the financial pressure on the NHS service has increased over the last few years. The 2009 annual nursing labour market review by the Royal College of Nursing (RCN) highlighted the effect of the global economic recession and the increased concerns of the impact on the UK nursing workforce (Royal College of Nursing Scotland, 2010), especially as the NHS has been facing financial difficulties for many years (Buchan and Seccombe, 2009). It has been argued that the recession may have a significant impact on nursing staff, not only reducing the number of nursing staff, but also expanding their role and productivity (Buchan, 2009; Buchan and Seccombe, 2009).

Key Messages in the Nursing Workforce in Scotland

Key Messages regarding Scottish nursing workforce are as follows.

- The number of RNs in NHS Scotland increased between 2000-2009
- International recruitment used to be one of the key strategies for increasing the nursing staff in the UK. but this is no longer the case
- The UK nursing workforce is ageing. It is expected that in the future there will be a need to replace those retiring RNs or delay their retirement
- Financial pressures are having an impact on the nursing workforce and healthcare delivery.

2.6.7 Policies: Preparing the Nursing Workforce for the Future in Scotland

Having discussed key issues regarding the Scottish nursing workforce, in this section government policies to maintain the nursing workforce in Scotland are discussed. It has to be noted that EU workforce policies are not reviewed and included in this literature review as the researcher's focus is Scotland only. Due to the large number of policies and reports related to the nursing workforce in Scotland, the researcher has focused on documents related to RQNs mainly in the last five years but with occasional reference to documents published since 2001.

Identifying grey literature

The supervisor first identified some relevant grey literature as the researcher was not familiar with NHS Scotland. After reading several documents, the literature search was extended by hand searches of references from the reviewed grey literature and the websites of the Scottish Government,¹³ NHS Education for Scotland (NES),¹⁴ and NHS Scotland¹⁵.

Key Health Policies and Government Document relate to Recently Qualified Nurses

It is important for the reader to understand the context of the NHS in Scotland and the resulting challenges for nurses in terms of delivering healthcare to the public. The following shows the key health policies and government documents that are discussed in the next sections.

Table 2-4: Key Health Policies and Government Document

Year	Health Policy	Strategy	Report/Project	Implementation
2001		Caring for Scotland	Facing the Future	
2002				One year job guarantee for nurses and midwives
2004			Nursing and Midwifery Workload & Workforce Planning 2004	
2005	Building a Health Service Fit for the Future Delivering for Health 2005			
2006		Delivering Care, Enabling Health 2006		Flying Start NHS (launching) Modernising nursing careers
2007	Better Health Better Care Action plan			
2008	Curam: Nurses, Midwives and Allied Health Professionals Working for Scotland's Health: Spring 2009		Leading better Care Report of the Senior Charge Nurse Review and Clinical Quality Indicators Project	Early Clinical Career Fellowships (launching)
2009				Education and Development Framework for Senior Charge Nurses
2010		The Healthcare Quality Strategy for NHS Scotland		

¹³ <http://www.scotland.gov.uk/Home>

¹⁴ <http://www.nes.scot.nhs.uk/>

¹⁵ <http://www.scot.nhs.uk/index.aspx>

Key Health Policies and Related Reports

Building a Health Service Fit for the Future [commonly called the Kerr Report after the Committee Chairman] was published in 2005 to meet changes in healthcare service and to anticipate future NHS requirements (Scottish Executive, 2005b). The Kerr Report identified a need for the following points to be addressed;

- Ensuring a sustainable and safe local service,
- Delivering the service in local communities rather than in hospitals,
- Drawing attention to preventative, anticipatory care rather than reactive management,
- Engaging people (not only NHS employers, but also patients and their carers) in changes to meet the challenge,
- Applying modern technology to improve the service and the speed of delivering care,
- Developing new skills and roles to support local services,
- Involving the public more in the process of developing solutions.

Emerging from the previous key messages, Kerr set out 10 proposals (Table 2-5) for what a future model of health care might look like. These proposals clearly showed the future direction of NHS Scotland.

Table 2-5: The future model of health care

<i>Current View</i>	<i>Evolving model of care (proposals)</i>
Geared towards acute conditions	Geared towards long-term conditions
Hospital centred	Embedded in communities
Doctor dependent	Team based
Episodic care	Continuous care
Disjointed care	Integrated care
Reactive care	Preventative care
Patient as passive recipient	Patient as partner
Self care infrequent	Self care encouraged and facilitated
Carers undervalued	Carers supported as partners
Low tech	High tech

Source: Reproduced from Building a Health Service Fit for Future', the Scottish Executive (2005)

Along with these 10 proposals, three factors were identified that were believed would determine the structure of the future NHS in Scotland; demographic changes (e.g. ageing population), workforce, and information and communication technology (e.g. telemedicine). The importance of workforce was emphasised in terms of defining the capacity of the NHS Scotland workforce to deliver government policy. In particular there were a number of challenges that applied to all frontline staff (Scottish Executive, 2005b). These included a shortage in the working age population, an altered work-life balance requiring more flexible working patterns, an increased demand for career breaks, shorten working hours as defined by the European Working Time Directive (1998), skill shortages in some areas (e.g. theatre) and difficulties in recruiting and retaining staff in remote and rural communities.

As a response to these challenges, the Kerr Report (2005a) proposed a re-designing of staff rotas, expanding or developing roles for NMAHPs (RNs, RMs and AHPs) and re-designing the structure of service delivery. In this way service re-design was born with departments created within NHS Scotland to carry through the required organisational changes; for example doctors and clerical staff changed the way they practised in relation to lung cancer patients by having radiology staff refer the patient directly to the respiratory clinic if a highly suspicious X-ray was found. This resulted in reduced waiting times so that patients were seen by respiratory physicians sooner (Scottish Executive, 2005a).

The Scottish Executive (2005) responded to the Kerr Report by setting out the priorities that they would work to for the next 10-15 years in the document 'Delivering for Health'(Scottish Executive, 2005b). The main policy aim was to improve the health of Scottish people, and to minimise the gap in life expectancy (Scottish Executive, 2005a). 'Delivering for Health' set up action plans to translate Kerr's recommendations into priorities for NHS service change Their focus was the following;

- Shift NHS from an acute hospital-centred to a community-based service,
- Tackle the two challenges of an ageing population and associated incidence of long-term conditions,
- Enhance the preventative health service rather than reacting to illness,
- Treat people faster and closer to home,

- Develop a health service that is proactive, modern, safe and embedded in communities.

As it can be seen the priorities focused on managing long-term conditions, caring for older people, encouraging self-care and delivering care in communities.

‘Delivering Care, Enabling Health’ (Scottish Executive, 2006a) was built on ‘Caring for Scotland’ and described how NMAHPs could contribute to implementing ‘Delivering for Health’ priorities. It set the direction for NMAHPs to deliver high quality, patient centred service to people in Scotland by meeting policy goals. In addition, the document gave NMAHPs a clear understanding of how they should change in order to meet these challenges. ‘Delivering Care, Enabling Health’ was presented in three sections: Culture and Context, Capability, and Capacity. Culture and context defined the principles of NMAHPs’ practice. Capacity described their contribution to Scottish health policy while capacity discussed the requirement for NMAHPs to meet the challenges of the future. The document highlighted that implementing ‘Delivering for Health’ required a sufficient and flexible capacity in the NMAHP workforce.

In 2007 the Scottish National Party (SNP) was elected to government and changes in policy followed. The new Scottish Government indicated five strategic purposes to create a more successful country. One of the strategic purposes was to encourage and improve Scottish people’s health by ensuring better, faster and more local access to health care. ‘Better Health Better Care’ (2007) gave a vision of a new NHS Scotland based on a more mutual NHS (Scottish Government, 2007a). Its action plans involved three components: health improvement, tackling health inequality, and improving the quality of health care. On health improvement, smoking, alcohol misuse, obesity, and mental health were the issues to be tackled. On health inequality, focus was paid to pregnant women, babies and young children to cut the link between early life difficulties and adult disease. On improving the quality of health care, ‘Better Health Better Care’ (2007) recognised that it was essential that ‘needed care’ should be as local as possible to the community it was serving. Workforce planning and the development of new roles among NMAHPs received attention as this was recognised as vital in order to meet the challenges of establishing the proposed new mutual NHS.

In the next section, reports and initiatives related to the nursing workforce are discussed within the context of the preceding health policies and reports.

Key Reports and Projects Related to Preparing the new Nursing Workforce

‘Caring for Scotland’ was published in 2001 by the Scottish Executive to provide nurses, midwives, the NHS, education providers and managers with a delineation of how they should respond to the challenges of delivering healthcare to the public. It covered role development, supporting the vulnerable patient, improving services for long-term condition patients and developing leadership. The important role of nurses and midwives was highlighted with particular attention paid to supporting RQNs and midwives. The lack of structured support for first year post-registration RNs and RMs and the importance of support to recently qualified nurses (RQNs) and midwives were stressed (Scottish Executive Health Department, 2001). It was suggested that the Scottish Executive would work towards implementing a programme providing structured support for RQNs and midwives by 2005.

In 2001, the Scottish Executive established a group to improve recruitment and retention within the nursing and midwifery workforce across the Scotland. The ‘Facing the Future’ Group was chaired by the Minister for Health and Community Care and supported by the Chief Nursing Officer (CNO), which meant that the group carried the authority of the government. Under the banner ‘Facing the Future’ (2001), several initiatives were undertaken to ensure that the nursing and midwifery workforce could meet the demands of the public and healthcare delivery (Scottish Executive, 2001). Eight themes emerged from a conference held with key stakeholders including nurses and midwives, managers, trade unions, professional bodies and regulatory bodies:

- Careers (One year job guarantee)
- Leadership
- Flexibility
- Education and training
- Working conditions and tools for the job
- Employment packages

- Research and evaluation (Nursing and Midwifery Workload and Workforce Planning Project)
- New roles.

Many documents were published by the 'Facing the Future' Group including various action plans and periodic updates on work progress (Appendix I). Due to the large number publications over the last decade, only those especially related to RQNs are described in the following paragraphs.

In 2003 a Consensus Conference was held called 'New Nursing Roles-Deciding the Future for Scotland' to examine issues related to new nursing roles, to identify the best evidence in nursing role development and to engage nurses in the process. Ten principles for nursing role development emerged from the Conference (Appendix II) In addition, it was recommended that a national framework be developed that integrated professional requirements, career structure, educational requirements and practice competencies. As a response to this recommendation, the Facing the Future group approved a steering group to work on a national framework for new nursing role development. The group membership was composed of service providers, professional organisations, education institutions and the Scottish Executive. A reference group was also established chaired by the Director of Nursing NHS Tayside to ensure wider professional examination. The document that emerged was, 'A Framework for Developing Nursing Roles' (2005c).

Under the theme 'Research and Evaluation', research was commissioned to examine nursing workload and workforce planning in Scotland and to develop a national picture of all key areas in nursing workload and workforce planning. The 'Nursing & Midwifery Workload & Workforce Planning Project' (2004) published 20 recommendations (Appendix III), which were accepted and taken forward by the Scottish Executive (2004). All recommendations were categorised into one of six themes; General, Principles, Education and Training, Systems, Allowances, and Research.

In 2006 'Modernising Nursing Careers' was published from one of the on-going 'Facing the Future' groups. Modernising Nursing Careers was a UK-wide initiative and part of the overarching strategy 'modernising healthcare careers'. It was intended to give direction to all registered nurses in their nursing career and to help employers to develop nursing careers locally (Scottish Executive, 2006b). It was stated that UK nursing was facing a

dramatic change that required nurses to take on new roles, to change the way they practised, and to work on new services to meet the needs of patients and the public. Four key points were addressed to develop modern nursing careers to meet these challenges. First there was a need to develop a competent and flexible nursing workforce. Secondly there was a need to update career pathways and career choices, and to prepare nurses to lead in a changed health care system. Finally it was necessary to modernise the image of nursing and nursing careers (Scottish Executive, 2006b).

The Knowledge and Skills Framework (Department of Health, 2004b)

And while all this was happening, it was agreed that the ‘NHS Knowledge and Skills Framework’ (KSF) was to be used for the implementation of ‘Agenda for Change’ (AfC) (Department of Health, 2004a). AfC was a new pay system that applied to all NHS employed staff except doctors, dentists, and the most senior managers. This new pay system was based on the principle that offers equal pay for work of equal value (Department of Health, 2004b).

The KSF framework provided a definition and description of the expected knowledge and skills of all NHS staff except doctors, dentists and senior managers. The main purposes of the NHS KSF were as follows:

- To facilitate the training and development to meet the needs of users and the public,
- To support the effective learning and development for all staff throughout their careers,
- To support their development to the level that is required within their post,
- To provide equal opportunity to develop to all staff.

Consequently, job descriptions and NHS KSF post outlines are provided for all NHS positions covered by ‘Agenda for Change’. A total of 30 dimensions are used to identify

the broad functions to deliver high quality service to the public of which six are core dimensions that apply to every post and are described in the NHS KSF post outline¹⁶;

- Communication,
- Personal and people development,
- Health, safety and security,
- Service improvement,
- Quality,
- Equality and diversity.

The other 24 dimensions are more specific as not all dimensions apply to all jobs in the NHS. The NHS KSF descriptions can be adjusted to the required job skills and applied to formal development reviews. It can therefore be seen that KSF ensures the required skills in their workplace were in the place linked with AfC and ensure that fair payment is allocated according to nurses' ability.

In the next section, key initiatives targeted at RQNs are discussed within the context of the previous health policies and initiatives. The link between KSF and Flying Start is described.

Key Initiatives Related to Recently Qualified Nurses-One Year Job Guarantee

In this section three specific initiatives are described: The 'One Year Job Guarantee' from Facing the Future, 'Flying Start' (FS) and 'Early Clinical Career Fellowships' (ECCFs) from Modernising Nursing Careers. Table 2-6 provides an outline of these three initiatives targeted at the recently qualified nurse. The 'One Year Job Guarantee' is ongoing and provides a one-year job guarantee for RQNs in NHS Scotland. The other two initiatives provide structured support to the recently qualified nurse during the transition process from a student to a professional nurse.

¹⁶ <http://www.paymodernisation.scot.nhs.uk/afc/ksf/>

Table 2-6: Key Initiatives related to Recently Qualified Nurses

Key Initiatives	Purpose	Features	Policy Context
One Year Job Guarantee¹⁷	To ensure that all RQNs and midwives can develop their clinical experience on the experience that gained from the pre-registration programme under the employment with NHS Scotland.	Ensuring a at least one year contract employment with newly qualified nurse and midwives who wish to work in NHS Scotland	Facing the Future
Flying Start¹⁸	To provide support for RQNs, midwives, and allied health professionals (AHPs) joining NHS Scotland during their transition process	Web-based, self directed programme Composed from 10 learning unit Link to KSF 150-200 hours to go through every unit The completion of this programme can be recognised as a evidence to move from Diploma in Higher Education to Ordinary Degree	Delivering for health Delivering care, Enabling Health
Early Clinical Career Fellowships¹⁹	To identify talented and motivated RQNs and midwives at early stage of their career and support them to develop their skills and their careers over the three year fellowship	Pilot programme with 99 fellows Protected study day leave Master course funded Completion of Flying Start required	Modernising Nursing Careers

The ‘One Year Job Guarantee’ (Scottish Executive, 2002) was introduced in 2002 in partnership with NHS employers, universities, professional organizations and NHS Education for Scotland (NES). The One Year Job Guarantee was designed to ensure that all RQNs and midwives could develop their clinical experience within NHS Scotland based on the experience from their pre-registration programme. Only when RQNs and midwives had tried and were unsuccessful in obtaining employment, could they contact NES. NES then provided them with a list of vacancies that offered at least one-year employment in Scotland. This initiative was still going on for 2010-2011 (Appendix IV)²⁰. In 2011, the government introduced a new internship model as a response to the current economic downturn (Scottish Government, 2011). The internship model emerged from the consultation with NHS boards and built on the existing One Year Job Guarantee scheme. It now provides RQNs with a clinical post for one-year, fixed-term, part-time (22.5 hours) and rotational employment in clinical practice with the link to ‘Flying Start’.

¹⁷ [http://www.nes.scot.nhs.uk/disciplines/nursing-and-midwifery/recruitment-and-retention/one-year-job-guarantee#Additional opportunities for NQN/M](http://www.nes.scot.nhs.uk/disciplines/nursing-and-midwifery/recruitment-and-retention/one-year-job-guarantee#Additional%20opportunities%20for%20NQN/M)

¹⁸ <http://www.nes.scot.nhs.uk/initiatives/flying-start>

¹⁹ <http://www.nes.scot.nhs.uk/education-and-training/by-discipline/nursing-and-midwifery/careers-and-recruitment/early-clinical-career-fellowships.aspx>

²⁰ <http://www.scotland.gov.uk/Publications/2010/08/one-year-job-guarantee>

Key Initiatives Related to Recently Qualified Nurses-Flying Start

In 2004, the Scottish Executive Health Department responded to the issue of RQNs having found their first job stressful and commissioned NES to develop an online, self-direct learning support programme with links to KSF and the e-library²¹. This programme, 'Flying Start', was launched in 2006 to support RQNs, midwives and allied health professionals (AHPs) (Hickie, Lyttle and Harris, 2007; Scottish Government, 2008).

Newly qualified NMAHPs work through Flying Start in their own time. There are ten learning components to be completed over 12 months; communication, clinical skills, teamwork, safe practice, research to practice, equality and diversity, policy, reflective practice, professional development, and career pathways (NES, 2006). Each learning component has sub-sections and 'concluding activities'. Learning outcomes are set for each component and sub-section and can be used by newly qualified NMAHPs as evidence for their portfolio for KSF development reviews. Approximately 150-200 hours are required to complete all ten components but not necessarily all activities in the programme (NES, 2006; Hickie et al., 2007). Mentors are allocated to newly qualified NMAHPs in their workplace, and are expected to register with the 'Flying Start' website. They provide mentoring and support for newly qualified practitioners to aid their progress and to complete the 'Flying Start' programme. Regular meetings with mentors should occur every three months and they should work together on this programme 2-4 hours per month. The completion of the programme is achieved by the following principles:

- "The learning outcomes of all ten learning units must be achieved
- A portfolio of evidence must be available (either electronically or paper) demonstrating sufficient evidence of the learning being applied in the workplace.
- There must be evidence of growth over time, i.e. the learner has demonstrated increased confidence and capability over the course of 12 months.
- All 10 concluding activities must be completed with clear objectives identified for the learner's personal development plan for the coming year."(NES, 2006)

²¹ <http://www.knowledge.scot.nhs.uk/home.aspx>

The completion of this programme can be recognised as evidence to move from a Diploma in Higher Education to an Ordinary Degree by submitting a 'Flying Start' portfolio (Hickie et al., 2007). However, there was no shared standard procedure or criteria for NMAHPs to complete Flying Start.

In 2010, an evaluation report was published based on research conducted over two years at three different Scottish universities (Banks, Kane, Roxburgh, Lauder, Jones, Kydd and Atkinson, 2010; NES, 2010). A multi-method approach was applied and data were collected by various ways such as literature review, interviews including focus group interview (n=94) and an online survey (n=547). The participants were managers (n=9), practice education facilitators (PEFs) (n=12), mentors (n=22), coordinators (n=21), newly qualified NMAHPs (n=94) and students (n=70). Research questions for the evaluation study and brief results and findings were as follows (Table 2-7).

Table 2-7: Research Questions and Brief Result and Findings (Banks et al, 2010)

Research Questions	Result and Findings
How does the model work?	<ul style="list-style-type: none"> ● The programme was developed and designed for all professions ● Due to the nature of work and working environment, the support given to the newly qualified practitioners needed to be adjusted and individualised. ● There were variation in the timing of enrolling on Flying Start ● The timing of introduction to Flying Start was argued ● There was a confusion in completing Flying Start ● An attention was paid to the need for support for all NMAHPs doing the programme ● There was a variation in terms of support in workplace, level of knowledge among mentors and recognition of the completion of Flying Start ● Newly qualified practitioner reported the difficulty of 'protected time' for the programme
What is the impact on recruitment and retention?	<ul style="list-style-type: none"> ● Majority of participant reported that there was no evidence that Flying start had an impact on recruitment and that Fling Start helped NMAHPs understanding of their future career.
What is the impact on recruitment directly into primary care?	<ul style="list-style-type: none"> ● All participants felt that the programme had been successful. ● PEFs and Managers expected to work in acute setting first to gain experiences that may need to work in the community
How does Flying Start NHS interface with other programmes?	<ul style="list-style-type: none"> ● NMAHPs noted that there are tensions and burdens to deal with Flying Start and other local orientation programmes. ● NMAHPs felt that some part of the programme contain many repetition of topic that they have learnt at universities

Source: Reproduced from Bank et al (2010)

Key Initiatives Related to Recently Qualified Nurses-Early Clinical Career Fellowships (ECCFs)

In 2007, ECCFs were commissioned by the Scottish Government and lead by the NES as one of the initiatives within 'Modernising Nursing Career' (NES, 2008). These three-year fellowships were piloted in NHS Scotland on behalf of the four UK countries. The purpose of the fellowships was to identify talented and motivated newly qualified RNs and RMs at an early stage of their career and to support them to develop their skills and their careers over the fellowship (NES, 2008; Pearson and Machin, 2010). This programme provided support to the Fellow to undertake a funded master's degree, be mentored, have protected learning time and career development advice.

There were five steps for application and selection for the Fellow; submitting the application form and CV, reviewing the application and selecting applicants to the next stage, psychometric testing for one day at an Assessment Centre and having a competency based panel interview(NES, 2008). The Fellows needed to be within two years of registration with the NMC and were required to;

- be an employee in a specific clinical area identified by a NHS Board during the Fellowship,
- be allowed the clinical delivery duty equivalent of one 7.5 hours day per week during the Fellowship,
- complete ‘Flying Start’ within the first year of qualification,
- complete a master’s degree relevant to their clinical setting and career aspirations,
- undertake ‘action learning sets’ regularly during the Fellowship,
- have a named mentor and meet with their Clinical Coach regularly during their Fellowship.

At the end of the fellowship, the Fellows were expected to be able to

- “Demonstrate extensive, detailed and critical knowledge and understanding in a specific clinical area, much of which is at or informed by developments at the forefront.
- Use a significant range of principal skills, techniques, practices and/or materials that are linked to the fellowship location while practicing in a wide and often unpredictable variety of professional level contexts.
- Apply critical analysis, evaluation and synthesis to issues, which are at the forefront or informed by developments at the forefront of practice.
- Use a range of specialised communication, ICT and numeracy skills to support and enhance care delivery.

- Exercise autonomy and initiative in professional and equivalent activities such as an
- Identifiable contribution to change and development.”²²

Over the course of the pilot, 100 Fellows were recruited over six occasions from 2007 to 2009 from 14 NHS Scotland Health Boards with 99 completing the programme (Pearson and Machin, 2010).

In 2010, the evaluation of the ‘ECCFs’ was published. The evaluation study was conducted within the framework of Realistic Evaluation Methodology (Pawson and Tilley, 1997) to systematically evaluate the relationship between key features, context (e.g. practice setting and culture, group make up), mechanism (e.g. course undertaken, mentoring, coaching and other processes), and outcomes (e.g. learning experiences-intended and unintended) (Pearson and Machin, 2010). Secondary data from the applicant selection process, observation of induction day, questionnaire (n=66, 79% response), and focus groups were conducted. The participant data were anonymised in line with ethics approval. Overall, the evaluation reported a positive view towards the Fellowship programme and Fellows were perceived positively among other staff. The Fellows found their degree programmes and action learning sets to be helpful and useful. However the clinical coaching was perceived as not helpful and they thought that managers lacked knowledge about the programme.

Summary

As can be seen from the preceding, NHS Scotland was trying to prepare staff for the challenges in health care delivery. The nursing workforce was acknowledged as playing an important role in terms of delivering healthcare to the people (Scottish Executive, 2005a; Scottish Executive, 2006b; Scottish Executive, 2006a). Initiatives were pursued to bring change in the shape of NHS Scotland. An attention was paid by the government to the support to the RQNs as several initiatives aimed to support their transition process from a student to a professional. However, it should be noted that at the time of writing a review of nursing and midwifery in Scotland is underway that will report in late 2012.

²² <http://www.nes.scot.nhs.uk/disciplines/nursing-and-midwifery/eccf>

2.7 Japan

2.7.1 Background of Japan

In this section, the background of Japan including the healthcare system, nursing and culture are described to give a broad understanding of the context of this study.

2.7.2 Geography and Sociodemography

Japan is an island nation located in the East Asia Pacific Ocean. It borders Korea, China and Russia through the Sea of Japan, the East China Sea, and the Sea of Okhotsk (Figure 2-9)

Figure 2-9: Map of Japan

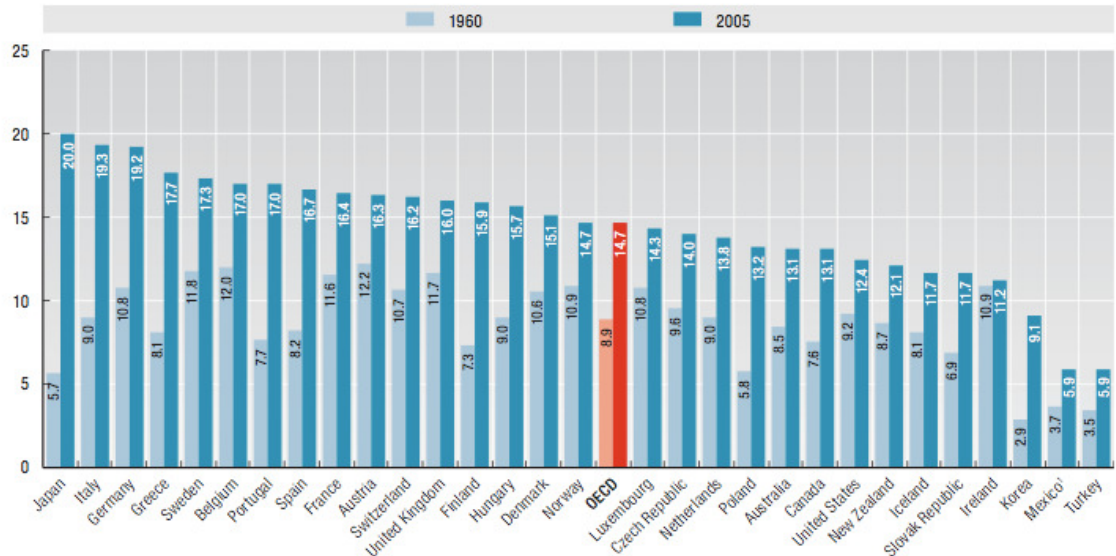


Source: Reproduced from United Nations Cartographic Section (retrieved August 2008)

In 2010, Japan had approximately 127.4 million inhabitants (MIACSB, 2010). After peaking in 2004, the Japanese population has gradually been decreasing. It is projected that in 2055, the population will be 100 million. In contrast to the decline in population, the population is ageing significantly. Japan has become one of the most ageing counties in the world. According to the 2005 Population Census in Japan, the population of 65 years and above was 25.6 million, 20.1 % of the whole population. This number has increased

dramatically over the last 50 years, which is much higher than other Organisation for Economic Co-operation and Development (OECD) countries such as France, Germany, USA, and UK (Figure 2-10). The latest projection report shows that by 2055 the population aged 65 and over will increase to 38 million and the share will rise to 40.5 % of the total population (National Institute of Population and Social Security Research, 2008).

Figure 2-10: Share of Population Aged 65 and Over



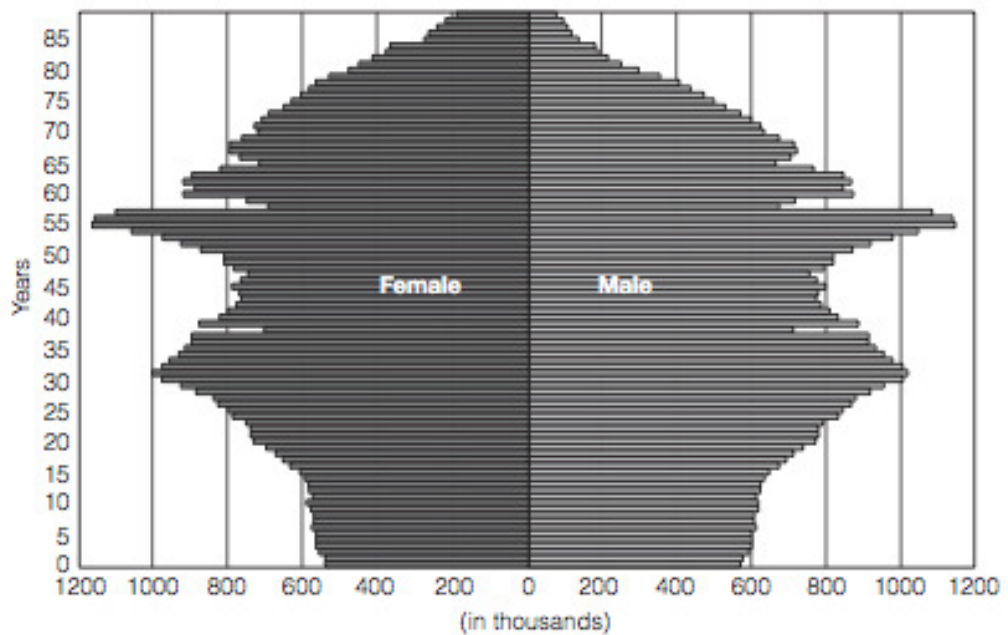
Source: Reproduced from OECD Health Data (2007) (OECD, 2007)

On the other hand, the younger population aged from 0-14 years will decrease for the next few decades. According to the 2005 Population Census in Japan, the younger population aged 0-14 was 17 million and is 13% of the entire population in Japan. Population projections show that by 2055 the younger population will drop to 7.5 million, which is only one fifth of the population of aged 65 and over.

These demographic changes have been caused by the decline in the birth rate and the consistent improvement in the mortality rate resulting in a collapsing of the population pyramid (Figure 2-11). There are two particular peaks that represent the 'baby boom'; one is after the Second World War and the other is in the 1970s (Japan Medical Association, 2007b). When the first 'baby boomers' retire in the next ten years, Japan will be the very first nation that confronts the fact that a quarter of its population is aged 65 and over. The total fertility rate has dropped sharply during the last six decades since the Second World War from 4.54 in 1947 to 1.34 in 2007. This number is lower than in most developed countries such as France (1.96), Germany (1.37), Spain (1.40), UK (1.90), USA (2.12)

(OECD, 2007). In addition, Japan has improved its mortality rate resulting in one of the longest life expectancies in the world; 86.05 for women and 79.29 for men.

Figure 2-11: Population Pyramid



Source: Reproduced from MIACSB (2005)

The declining birth rate combined with an improved mortality rate over the last few decades has led to the current significantly ageing population in Japan. The ageing population has significant influences on society and industry in Japan and places considerable burdens on the health care delivery system and its workforce.

2.7.3 Political and Economic Status of Japan

Japan is a constitutional monarchy with a parliamentary government. There are 47 prefectures and 1,750 municipalities (Local Authorities System Development Centre 2008). The country is governed by a cabinet that the prime minister appoints. National policies are set by the parliament and ministries such as the Ministry of Health, Labour and Welfare (MHLW) who structure the details of policies. Lobbying groups have some influence on the process of detailing policies. Local government is composed of two levels; prefectures and municipalities such as cities, towns and villages. Since 1995, the national government has encouraged the merger between municipalities and as a result the number of municipalities has decreased but they have an important role in providing social services and health care.

The Japanese economy has developed rapidly over the last few decades, especially during the 1960s and has become one of the most industrialized countries since the Second World War. During the 1960s and the early 1970s our Gross Domestic Product (GDP) growth rate was around 10% annually. After the sudden drop of the GDP growth rate following the 1973 Oil Crisis, Japanese economic growth became more gradual. In 2008, the GDP growth rate hit its worst record, -3.7% because of the world recession. However, GDP was 5,067 billion US dollars (World Bank, 2009) and Japan is second in the GDP world ranking.

The current economic situation can be reflected by the unemployment ratio. It increased to 5.1 % in 2010 from 3.9% in 2007. The labour force population aged 15-65 years old hit a peak of 68.08 million in 1998 and started to decrease gradually. There were 62.78 million people (56.8% of entire population) working and 3.34 million people being unemployed in 2010 (MIACSB, 2011).

For the last couple of years, income inequality has received much attention from the public due to national policy changes. According to the National Survey of Family Income and Expenditure, income inequality has increased in the population aged 65 and over and this is likely to have some impact on health and social disparity (Kondo, 2005; Kawakami, Kobayashi and Hashimoto, 2006).

2.7.4 Health Care System²³

In the following section, the healthcare system in Japan is discussed to provide a brief understanding of the Japanese healthcare system and as background for issues in the nursing workforce.

History of Contemporary Health Care System

Japan's health care system is built on the structure of a social health insurance system that is a core element of its social security system providing medical care benefits and pensions for sickness, injury, childbirth, death, ageing and disability (Tatara and Okamoto, 2009). Social security in Japan has been influenced by the British and German social security systems. Japan's first social security system 'Jukkyuu-kisoku' was introduced in 1874 (Tatara and Okamoto, 2009). This had a similar function to the 'Poor Law' in the UK. The

²³ <http://www.mhlw.go.jp/bunya/iryouhoken/iryouhoken01/01.html>

health insurance system was introduced in 1927 for all employed people with one for the self-employed enacted in 1938. After the Second World War, the Japanese government established a social security system according to the new constitution that was enacted in 1947. During the 1950s to 1970s, Japan's 'post-war economic miracle' period, the government improved the quality of social security as a response to economic growth (Tatara and Okamoto, 2009). In the 1950s one third of the population, approximately 30 million people did not have any health care insurance. The government introduced universal coverage of social insurance including health care insurance in 1961 and provides every citizen an equal opportunity for treatment at a fixed premium (Tatara and Okamoto, 2009). Since 1961, medical care in Japan has improved for the purpose of delivering every citizen's well being.

Overview of Health Care System

In Japan, curative and preventative health services are funded differently and have different functions for care delivery (Tatara and Okamoto, 2009). The curative health service is funded by health insurance, general tax and patient contribution and provided by private and public healthcare professions. Preventative health is funded by general tax and usually local and municipal government provide most public health in a public health centre. The Ministry of Health, Labour and Welfare (MHLW) is the central government body responsible for setting policy on Japanese healthcare.

Health Insurance²⁴ (Table 2-8)

Under the universal coverage principle, all registered residents of Japan must enrol in the appropriate social health care and pension insurance system²⁵. There are two main social health care insurances system; one for the employed population and their family members; the other one for self-employed or unemployed including the retired population and their families (MHLW, 2010f). These two social health care insurances are categorised into four different insurances according to the current employment status of the employee. National Health Insurance (NHI) is for the self-employed and unemployed including the retired population and is run by municipal government (MHLW, 2010f). Government Health Insurance (GHI) is for employed people and their dependants working for small companies

²⁴ The information is from this website: <http://www.sia.go.jp/seido/iryo/index.htm> and <http://www.mhlw.go.jp/bunya/iryouhoken/iryouhoken01/01.html>

²⁵ <http://www.sia.go.jp/seido/index.htm>

and factories and managed by the Japan Health Insurance Association (MHLW, 2010f). The Society Health Insurance (SHI) is for employees and their dependants working for bigger companies that can establish their own association for health insurance. The fourth insurance is Mutual Aid Society Health Insurance (MASHI) for national and local government employees and their dependants.

In addition to the four different insurances, there is a separate health care system for the elderly population aged over 75 (MHLW, 2010f). Initially, the Welfare Service for the Elderly Act was passed in 1963 and NHI covered the cost of the medical treatment for the elderly population and elderly people did not need to contribute medical costs (Tatara and Okamoto, 2009). However, free medical care for elderly people resulted in increased medical costs and gave financial difficulty to the NHI system. Thus, the government introduced the Health Service for the Elderly Act in 1983. Under this act, the finance of health service for the elderly population was separated from the general population. However, this health insurance system for the elderly population aged over 75 still faces several issues and is still being reformed because of increased medical costs, the ageing population, the recent recession and the recent taking over of the reins of government by the democratic party (MHLW, 2010f).

Once enrolled in the health insurance system, you need to pay a fixed premium to the insurer directly (MHLW, 2010f). The premium for SHI is fixed based on 3-10 % of your monthly wage and is shared between employee and employer equally. The rate for GHI is fixed at 8.2% of monthly salary and shared between employer and employee. The MASHI's is also fixed according to monthly wage and the rate for NHI is decided by each local government and is around 9% (Japan Health Insurance Association, 2010).

In addition to the national health insurance, a voluntary health insurance exists in Japan, that covers the patient contribution for the medical cost of special occasions such as surgery or long term hospitalisation and special medical treatments not covered by national health insurance (Tatara and Okamoto, 2009). The private insurance companies usually manage this insurance. The portion of the medical treatment that covered by voluntary health insurance is not calculated as it is expected that it would be small because of the universal coverage of the entire population.

Table 2-8 : Health Insurance System in Japan

Age from 0 to 74				
Employed status	Employed			Self-employed Unemployed Retired
Employer	Small or medium sized company or factory	Bigger sized company	National or Local government	None
The insurer	Japan Health Insurance Association (Government Health Insurance- GHI)	Company Insurance Association (Society Health Insurance-SHI)	Provident Society (Mutual Aid Society Health Insurance- MASHI)	Local Government (National Health Insurance-NHI)
Number of assured (Including dependants)	35,843,000	30,119,000	9,587,000	51,627,000
Premium	8.2% of monthly wages	3-10% of monthly wages	3-10% of monthly wages	Depend on local government Ranged from 9.26 to 9.42%
Contribution of the actual medical cost at	20% for preschool children 30% for school age children to 69 years old 10% for 70 years old and over			
Age from 75 and over Healthcare Service for Elderly Act (for elderly aged 75 and over)				
The insurer	Number of assured		Premium	Contribution of the actual medical cost
Local Government	13,000,000		Decided by local government based on income	10%

In the next paragraph, more detail about the health insurance, especially remuneration, is provided as the remuneration is one of the key incentives to implement the Japanese Government policies and has had direct influence on the nursing workforce (Tatara and Okamoto, 2009).

The range of health care covered by the health insurance and medical treatment fee schedule for remuneration is decided and revised every two years by the government. Every health care intervention is counted as points and hospitals claim remuneration with 'Rezept', which contains the information of the health care intervention provided to patients. Health Insurance Claims Review & Reimbursement Service or the Federation of National Health Insurance then audits the 'Rezept' (Tatara and Okamoto, 2009). After the

audit, the 'Rezept' is sent to the insurer and they pay the remuneration to the hospitals through these audit institutions. Patients need to pay the fixed portion of the contribution for the health service according to their age and also need to show that they are enrolled in one of the appropriate health insurance schemes at the hospital (MHLW, 2010f).

The Central Social Insurance Medical Care Committee is an advisory committee on revising fee schedules. Revision of medical treatment fee schedules for the remuneration plays an important role for the government in terms of implementing health policy. It changes not only the price of the health service, but also designating health service provider incentives to implement certain health policies by setting up the prices for the certain kind of health services.

Delivery of Health Care

As mentioned earlier, public health centres in each municipality provide preventable health care. Curative health care is provided in hospital and clinics. According to the Survey of Medical Institutes 2009 (MHLW, 2010b), there were 176,471 medical institutes, composed of 8,739 hospitals, 99,635 medical clinics, and 1,079 'Psychiatric Hospitals'. A total of 6.2% of general hospitals have beds for long-term care. The number of hospitals hit a peak in 1990 and since then it has been decreasing. A total of 70% of hospitals are private and they have half the number of total beds, 1.7 million beds, in Japan. This feature is unique in Japan and the private sector plays a very important role in terms of delivering health care to the Japanese population.

All public and private hospitals and clinics are opened to every patient. Thus patients can choose any hospital and clinic at their first contact (Tatara and Okamoto, 2009). If the patient needs some particular interventions, such as surgery, a highly specialized diagnostic procedure, they are referred to other hospitals. There is no similar system to GPs as in the UK. Thus, residents can receive specialized care directly without a referral process (Tatara and Okamoto, 2009). However, there are also some disadvantages as this system can result in unnecessary medical treatment. Recently the government introduced a new referring system for the university hospitals and other hospitals with special function such as the core local hospital or teaching hospital.

Finance of Health Care System

The Japanese government estimates National Medical Care expenditure annually, a sum of remuneration to hospitals and clinics that provides curative medical health care within the coverage of health insurance. ‘Medical Care Expenditure’ dramatically increased in the 1960s and 1970s because of economic growth and also the establishment of the universal coverage of Japanese population. In 2007, ‘Medical Care Expenditure’ was 34,136 billion Japanese yen and annual health expenditure per capita was 267.2 thousand yen. The ratio of ‘Medical Care Expenditure’ against national income was 9.11% and this number has been increasing gradually for the last 20 years between 1998-2007 (MHLW, 2009d).

2.7.5 Nursing in Japan²⁶

In this section, a brief history of Japanese nursing and nurse education are discussed to provide a background for key issues related to the Japanese nursing workforce.

History of Japanese Nursing System and its History

The foundation of the Tokyo Voluntary Hospital Nursing School in 1885 was the beginning of the Japanese nursing system (JNA, 2006). After this first Japanese nursing school, several nursing schools were founded with American and English nurses. In 1915, the promulgation of ‘Registered Nurse Ordinance’ ensured the national standard of nursing qualification. After the Second World War, the new act ‘Public Health Nurses, Midwives and Nurses Act’ was introduced in 1948 and established the foundation of the modern nursing education in Japan (MHLW, 1948). This law changed the status of the nursing profession and all candidates for the nursing profession were required to pass the national exam board for the formal licensed qualifications (JNA, 2006). The jurisdiction of nursing education was given to the MHLW. Thus, most of early nursing education was outside of higher education institutes. Currently, there are three recognised, nationally authorised nursing professions; ‘registered nurse (RN)’, ‘public health nurse (PHN)’, ‘midwife (RM)’ (JNA, 2006).

In addition there are locally authorised ‘assistant nurses’ (AN) in Japan. The assistant nurse system was introduced in 1951 due to the shortage caused from the increased number of hospital beds. In 1964, a new nurse education system for assistant nurses was introduced.

²⁶ <http://www.nurse.or.jp/jna/english/nursing/index.html>

In 1952, the first four-year university nursing course was introduced and the Ministry of Education took the jurisdiction over university nursing education. In the early 1990s, there were only nine universities that provided nursing education. However, this increased dramatically during the 1990s to 91 universities within a decade.

There are several explanations for this significant increase. Firstly, in 1992 there were legislative changes in the Medical Care Act originally passed in 1948 (MHLW, 1948; Yoshikawa, 2003). These changes resulted in a shortage of nursing staff. Secondly, as a response to increasing demands for nursing staff caused by legislative change, the ageing population and developed medical technologies, legislation on encouragement to maintain the nursing workforce was introduced by way of the Nurse Provision Act (Yoshikawa, 2003). In addition, the report of the consensus conference about the current nursing system stated that there was a need to expand nursing education in higher education including undergraduate and postgraduate levels and organising the nursing training system and standardising of the nursing education (MHLW, 1987; JNA, 2006). In 1992, the Ministry of Home Affairs (now the Ministry Home Affairs and Communications) announced that they would provide financial support to establish nursing in universities (Yoshikawa, 2003) as a response to the Nurse Provision Act. This announcement triggered a dramatic increase in the number of universities providing nursing education. The latest statistics show in 2009 there were 183 universities in Japan that produced 14, 322 new nurse graduates (MHLW, 2010a). The following Table 2-9 outlines a brief history of Japanese nursing.

Table 2-9: Brief History of Japanese Nursing²⁷

Year	Principle Legislation	Other Important Event
1876		Meiji Restoration The Japanese term for nurse is used for the first time
1885		The first nursing training institute, the Tokyo Voluntary Hospital Nursing School.
1915	Passed the Registered Nurse Ordinance	
1945	The Second World War ends	
1948	Medical Care Act Public Health Nurses, Midwives and Nurses Act	
1951		Assistant nurse introduced into practice
1952		First four-year university nursing course
1987	The MHLW reports the need for establishing more undergraduate and postgraduate nursing course and organising the nursing education.	
1992		The Nurse Provision Act

²⁷ <http://www.nurse.or.jp/jna/english/nursing/index.html>

Becoming a Registered Nurse in Japan

The Japanese nursing pre-registration system is rather more complicated than the UK system. There are six pathways to be a RN in Japan. After nine years of compulsory education, with or without an additional three years of high school, there are two main streams to enter the nursing education system (JNA, 2006). Currently, the most common pathway is nursing education following a high school diploma.

Nursing students go to a university (4-year bachelor's degree course combined with public health nurse and midwifery), or to a junior nursing college (3-year course, diploma or junior colleague degree course), or to a nursing training school (3-year course diploma course). Another way to become a RN is to gain the assistant nurse qualification first and then a shortened RN qualification course (two-year course, diploma course). All nursing students are required to take the national board examination for registration. The pass rate has ranged from 84 % to 91% over the past ten years. Once you are qualified, the qualification is valid forever as there is no registration renewal system in Japan unlike the UK (JNA, 2006).

The result of the above systems is that there are two qualifications for nursing; that is a RN qualified by the MHLW and an assistant nurse (AN) qualified by the local prefectural government. In the 'Public Health Nurses, Midwives and Nurses Act' (1948), it states that the assistant nurse provides nursing care under instructions from medical doctors, dentists and RNs (MHLW, 1948). However, there is no difference between the nursing care provided by RNs and assistant nurses and they end up doing the same job under a different salary and social status (JNA, 2006). Some comment indicate that the assistant nurse system is a possible cause of the low value of nursing in Japan and worsens the quality of nursing care (MHLW, 1996; Yoshikawa, 2003). In 1996, the report of the 'Consensus Conference for issues regarding the assistant nurse system' suggested that there was a need for the integration of the two nursing education systems including the abolition of the assistant nurse system in the 21st century (MHLW, 1996). However, this has not happened yet due to conflict between health professional organisations (Japan Medical Association, 1996).

Table 2-10 shows the educational background of new graduates. A total of 32,258 new graduates, of which 68% of all new graduates had high school diploma (MHLW, 2010a) and 22% of all graduates had bachelor's degree.

Table 2-10: Educational Background of New Graduates and Their Pathway 2009

	University (4 years)	Nursing Junior College (3years)	Nursing Training School (3 years)	Nursing Junior College (2 years)	Nursing High School (5 years)	Nursing Training School (2 years)	Total
Newly graduate	10,560	1,740	19,958	364	2,754	11,592	46,968
Employed as nurses (includes PHN/RM)	9,529	1,348	1,8191	326	2,582	10,392	42,368
Employed outside nursing	197	250	247	0	40	97	831
Further Study	496	12	917	9	78	98	1,610
Others	338	130	603	29	54	1,005	2,159
Total of graduates outside nursing	1,031	392	1,767	38	172	1,200	4,600

Source: Reproduced with modification from MHLW (MHLW, 2010a)

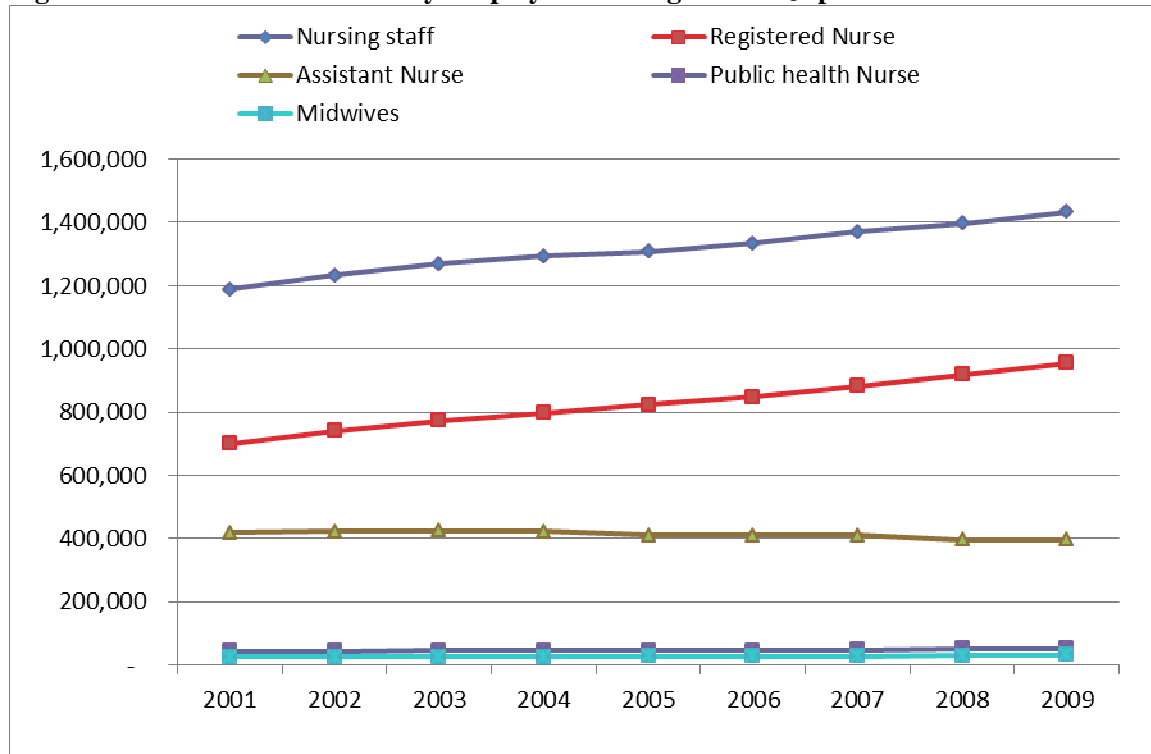
2.7.6 The Nursing Workforce in Japan

The next few paragraphs highlight the current situation in Japan in the context of issues and challenges related to the nursing workforce, policies. These are presented in the same order as the challenges in Scotland (2.6). However, several topics are omitted or added as the challenges for the nursing workforce in Japan are different from Scotland.

Demographic Data on Nurses: How many nurses are there?

The number of nursing staff (RNs, ANs, RMs, and PHNs) has dramatically increased over the last few decades from 210,000 in 1957 to 1,433,772 in 2009 (JNA, 2007a; JNA, 2010a). According to the MHLW, the number of currently employed nursing staff has consistently increased during 2000-2008 (Figure 2-12). In particular, the number of RNs increased whereas other nursing staff stayed almost the same (JNA, 2010a).

When you compare the number of nursing staff to other countries, the latest OECD figures (2009) indicate that the average number of nurses per 1000 population in Japan is 9.4 a slightly smaller than the average among other OECD countries. However it should be noted that the average number of all nurses increased by 2% over the last 10 years (OECD, 2009).

Figure 2-12: Number of Currently Employed Nursing Staff in Japan

Source: Redrawn from JNA (2010a)

According to the latest report, 7th Conference of Forecast for Supply and Demand for Nursing Staff, it was estimated that demand for all nursing staff (includes RNs, RW, PHNs and ANs) will increase to 1,500,900 by 2015, and there will be a shortage of 14,900 nursing staff (MHLW, 2010c). However, the interpretation of these figures by the government has to be carefully done for two reasons.

Firstly, how the government counts the number of nursing staff varies depending on the report. The number of all nursing staff currently employed as nurses was counted by head count whereas the number of demand and supply nursing staff was calculated as full-time nurses. Thus it is difficult to compare just the numbers (MHLW, 2005a; MHLW, 2010c).

The other reason is there is no standard tool to estimate the demand for nursing staff. The methodology to estimate the nursing staff demand and supply varies with each hospital and organisation. The estimation of demand for nursing staff and actual supply was based on self report submitted by the Directors of Nursing at each hospital and by local governments (MHLW, 2010c). They estimated the number of nursing staff based on the government policies, legislation changes, and nursing working environment at each hospital. Thus, the working environment, such as paid holiday, staffing levels, and salary, is different and how it will be improved depends on the each hospital's management policy.

The Japanese Nursing Association (JNA) publishes an annual report about the current situation of nursing staff demand and supply in hospital based on the postal survey. A survey was sent to all hospitals (n=3,766, response rate 42.9%) in Japan to investigate the employment status of nursing staff in the hospital. According to the latest report published in 2010, overall turnover rate among nursing staff dropped to 11.9% after 5 years as well as the turnover rate RQNs (turnover rate 8.6%). However, there was no report on the demand and supply balance of nursing staff.

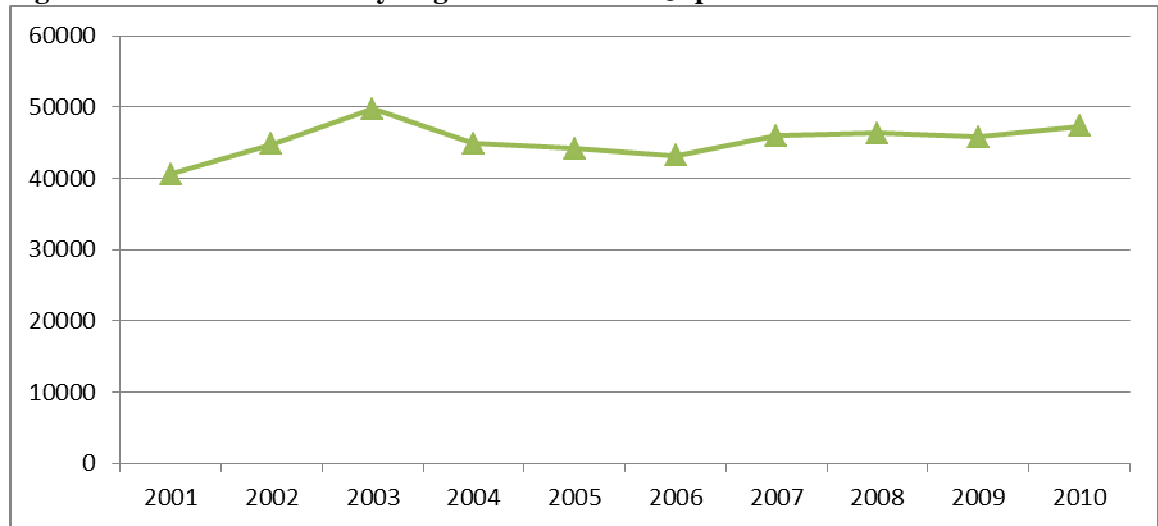
Therefore in summary, the number of nursing staff (RN, RW, PHNs and ANs) constantly increased during 2001-2008, in particular RNs. It is difficult to conclude whether there is a shortage of nursing staff in Japan or not based on figures provided by the Japanese government (most recent issue regarding shortage of nursing staff is discussed in 2.7.7). In contrast to Scotland where the policy and financial situation make an impact on healthcare service including the number of employed nursing staff, it is difficult to see the impact of policies and financial status on the healthcare service from these data discussed above.

Pre-registration nurse education in Japan is not fully funded by the government.

Figure 2-13 shows the number of new RNs in Japan. It has not changed dramatically during 2001-2010 and remains around 45,000 annually (MHLW, 2010d). However, not all of RQNs go in clinical nursing. According to the latest statistics of new graduates' career choices at graduation (MHLW, 2010a), 10% of new graduates, including new graduates who have failed to pass the national exam board, did not go into nursing practice.

The number of applicants for universities in Japan has been decreasing since 2002 because the population is producing fewer children (National Center For University Entrance Examinations, 2010). Even so (2.4.2), the number of applicants for pre-registration nursing courses in the universities is increasing as a response to the current economic situation (Kawai-Juku, 2010).

Therefore, in summary, Japan has been able to provide a constant supply of new RNs every year despite the fact that the younger population is decreasing and it does not seem there is an issue in recruiting new generations into clinical nursing.

Figure 2-13: Number of Newly Registered Nurses in Japan

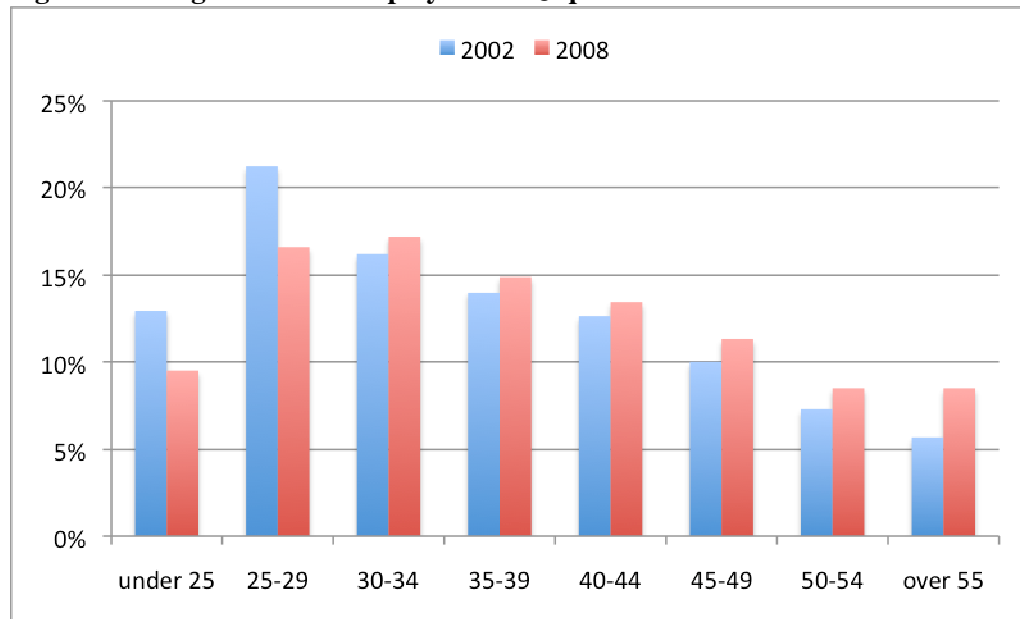
Source: Original diagram, compiled from information in MHLW (2010d)

International Recruitment

International recruitment of RNs has never been a practical solution for Japan's shortage of RNs in the 1990s and 2000s due to the legislative changes (2.7.5 and 2.7.7) because of language and cultural issues. For example Economic Partnership agreements signed with Indonesia in 2007 and the Republic of the Philippines in 2006 only produced 19 registered nurses who had passed the national board examination by 2011 (MHLW, 2009a; MHLW, 2010e; MHLW, 2011c).

Ageing Workforce

The Japanese nursing workforce is not as 'old' as the workforce in Scotland and the UK (2.6.4). Figure 2-14 shows the age profile of employed RNs in Japan. In 2008, more than 25% of all employed RNs were aged less than 30 years and only 17% of all employed RNs were aged over 50 (MHLW, 2011b). This compares to less than 10% of RNs under 30 years old and more than 30 % RNs over 50 in Scotland.

Figure 2-14: Age Profile of employed RNs Japan 2002 and 2008

Source: Original diagram, compiled from information in MHLW (2011b)

Inactive Nurses

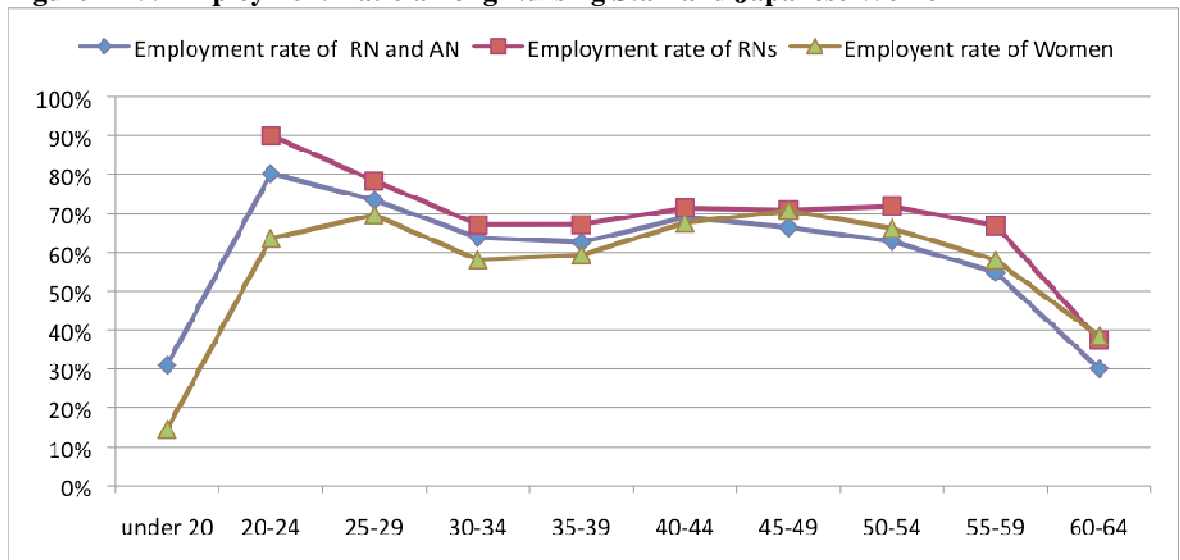
As noted before (2.7.5), there is no registration system for qualified nurses in Japan. The lack of a registration system is often pointed out as an issue in nursing workforce planning in Japan as there is no way to know the exact number of nursing staff currently employed (MHLW, 2005b; JNA, 2007b). In 2004, the MHLW estimated the number of qualified nursing staff (RNs and ANs) of 65 years or under to be 1,766,981, of whom more than one third (31.11%; 549,783) were not working as a qualified nurse in 2002. These figures are based on the number of graduates from nurse training institutes (universities, college, and nursing schools), the distribution of age at entry to nurse training institutes, and the pass rate at the national board examination (MHLW, 2004a).

In 2007, Japanese Nursing Association conducted a postal survey with unemployed nursing staff (RNs, RMs, PHNs, and ANs) (n=3,643) and retiring nursing staff (n=454) to examine their perceptions of employment. The postal questionnaires were sent to those who volunteered. The recruitment was conducted through internet, the government conference, mass media, alumni, Japanese Nursing Association and so on. The average age of currently unemployed nursing staff was 38.7 years old, 98.5% were female, 79.0% were married, 70.1% had children, and 88.4% were RNs. The most common reason for having left their last job (multiple choices) were pregnancy and labour (30.0%), marriage (28.4%), length of working hours (21.9%), raising children (21.7%) and the over workload of the night shift (17.8%). Of these nursing staff, 77.6% were willing to return to clinical nursing, but not able to return due to parenting (49.9%), housework (22.1%), and the lack of

confidence to be a competent nurse (20.6%). The rest of nursing staff, 22.4% was not willing to return to clinical nursing due to a health condition (29.8%), the heavy responsibilities and pressure (25.7%) the lack of confidence to be a competent nurse (21.5%).

Ninety-six percent of RNs and 95% of ANs are women (MHLW, 2011b). Generally both RNs' and ANs' employment is broadly similar to and a reflection of Japanese women's life style (Nakata and Miyazaki, 2008). As can be seen in Figure 2-15 there is a 'M-shaped' employment pattern with two peak employment periods for nursing staff (RNs and ANs) and Japanese women generally. For both, employment peaks at 20-24 years and drops during the 30s, probably due to marriage and childbirth (JNA, 2007a; JNA, 2007b). Employment increases again among the age range 40-44 years when women including nurses return to work and until the retirement age of 60 years.

Figure 2-15: Employment Ratio among Nursing Staff and Japanese Women



Source: Original diagram, complied from Nakata and Miyazaki (2008) and MIASCB (2010)

In summary, there is a large number of qualified nurses who are not employed. Their reasons for being unemployed are marriage, childbirth and parenting, which are common among Japanese women. However, there are couple of reasons that are specific to the nursing working environment and nursing role itself such as workload and night shift.

Key Messages for the Nursing Workforce in Japan

Key Messages regarding Japanese nursing workforce are as follows.

- The number of nursing staff, especially RNs, increased steadily during 2001-2008

- The estimation of extra 14,900 nursing staff will be needed by 2015
- There is consistent inflow into nursing annually and 20% are university graduates
- The entry to pre-registration nursing is constant but the younger population is decreasing
- There are 550,000 RNs and ANs who are not working

2.7.7 Policies: Preparing the Nursing Workforce for the Future in Japan

In this section, government policies to maintain the nursing workforce in Japan are discussed. Due to the large number of policies and government documents related to the nursing workforce, the researcher focused on documents published in the last 10 years related to recently qualified nurses (RQNs). The presentation of the policies differs from Scotland due to the following reasons. Firstly, Japan's organisational structure is different and our documents obviously have different titles. Secondly, the process of developing government policy differs from Scotland in that the Scottish documents read for this thesis clearly state how the policy was developed and how it relates to other government documents. On the other hand it was difficult to understand the link between Japanese policies and other government documents. In order to avoid the confusion and provide comprehensive understanding of the Japanese context, wherever possible the researcher gives the same headings as Scottish literature.

In the following sections, the process of identifying key government documents and key policies is discussed.

Identifying grey literature

The literature search for this section was conducted mainly by hand searches. The researcher had an informal discussion about the Japanese nursing workforce with previous colleagues, former managers in Kobe, and the mentor for this study in Kobe University, Japan. During the discussion, several policies and legislative changes were identified. The

researcher reviewed these government documents and identified other documents from the reference lists. Most of the documents were located on the website of the MHLW²⁸.

Key Health Policies and Government Document relate to Recently Qualified Nurses

As mentioned before, it is important for the reader to understand the context of the Japanese healthcare service with health policies and current challenges for the Japanese nurse workforce in terms of delivering healthcare to the public. Table 2-11 shows key policies, legislation, and government-led consensus conferences and projects related to health and workforce. As with Scotland only those that are related specifically to RQNs are discussed in detail.

²⁸ <http://www.mhlw.go.jp/>

Table 2-11: Overall Key Policies, Regulations, Government Report and Project Related to Recently Qualified Nurses

Year	Health Policy and Social Security Policy	Related legislation and regulation change	Consensus conference	Government funded Project
2001		Public Health Nurses, Midwives, and Nurses Act Nurse Provision Act		
2003	Vision of a Reformation in Healthcare Service Delivery System		Report of contemporary and future nursing practice Report of nursing clinical skill education in the pre-registration programme	
2004		Regulation change in medical treatment fee schedule for remuneration	Report on the advancement of clinical nursing skills among RQNs	
2005			Report on 'Public Health Nurses, Midwives, and Nurses Act' to secure patient safety. The report of the sixth term forecast for supply and demand of nursing staff.	
2006		Public Health Nurses, Midwives, and Nurses Act Medical Care Act Regulation change in medical treatment fee schedule for remuneration		The project of maintaining the nursing workforces by Japanese Nursing Association
2008	Five Security Plan Vision of a Secure and Reliable Healthcare Service	Regulation change in medical treatment fee schedule for remuneration		The model project for the patient safety among RQNs
2009		Public Health Nurses, Midwives, and Nurses Act Nurse Provision Act	Middle term report on the quality of nursing care and maintaining nursing workforce	
2010		Regulation change in medical treatment fee schedule for remuneration	The report of the seventh term forecast for supply and demand nurses.	The project of orientation training programme for RQNs
2011			Report on the orientation training programme for RQNs	

Key Health Policies

In the last decade, three main policies related to healthcare service, ‘Vision of a Reformation in Healthcare Service Delivery System’ (2003), ‘Five Security Plan’ (2008) by the Japanese Cabinet Office, and ‘Vision of a Secured and Reliable Healthcare Service’ (2008) were published.

In 2003, the MHLW established a working group, led by the Minister of the MHLW, to review reforming the healthcare service. A sub-group examined specifically the redesign of healthcare delivery and held public hearings. From these meetings emerged the ‘Vision of a Reformation in Healthcare Service Delivery System’ in 2003 (MHLW, 2003c). This document was a response to the increased awareness of the necessity of the health care service to respond to demographic changes, advanced medical technology and increasing expectations among the public about a better health care system. This vision identified five objectives to be achieved:

- To improve the delivery of information regarding healthcare service for patients,
- To secure local healthcare service,
- To promote specialisation and collaborations between healthcare providers,
- To improve the quality of the healthcare professions (medical doctors, NMAHPs) and their retention and recruitment,
- To maintain and improve the foundation of the healthcare service.

The MHLW clearly stated the direction of the proposed reformation of the healthcare service, similar to the Kerr Report (2005) and suggested that government would work on achieving these changes. As a response to ‘Vision of a Reformation in Healthcare Service Delivery System’ a number of consensus conferences (e.g. paediatric care, maternal health etc) were held in order to discuss how to move the policy forward. For the purposes of this study only the ‘Report on Public Health Nurses, Midwives, and Nurses Act to secure patient safety’ (2005) is discussed.

In June 2008, the MHLW published a new policy regarding healthcare service. ‘Vision of a Secured and Reliable Healthcare Service’ (similar to ‘Delivering for Health’ and ‘Better

Health, Better Care' in Scotland) set out to provide a secure healthcare service to all citizens and provide high quality healthcare within limited resources (MHLW, 2008). The focus was on the following three points:

- Maintaining the appropriate number of healthcare professions and review of their role,
- Establishing a healthcare service network in each local area,
- Collaboration between healthcare professions, patients, and their family members.

The number and working environment of medical doctors was one of the main focuses of a 'Vision of a Secured and Reliable Healthcare Service' and became a central issue when it was announced that there was a shortage in the absolute number of medical doctors (Japan Medical Association, 2007b; MHLW, 2007b). Additionally, the emergency healthcare system and the working condition of medical doctors received much attention from the public due to an event that happened in 2005. A pregnant woman died due to brain haemorrhage immediately after she delivered a baby, but early symptoms were not noted and she was not treated properly (asahi.com, 2006). This event stimulated much discussion and confusion in the public about the healthcare system. In 2008, the government budget for maintaining the absolute number of medical doctors was increased by 74% (MHLW, 2007a; MHLW, 2007b).

In addition to the three main focuses, several key points were presented in each focused issue. Increasing the employment of nursing staff and reviewing the role of nursing staff were included as a part of the actual action plan (MHLW, 2008). However, maintaining the appropriate number of nursing staff was in the context of improving the working environment of medical doctors and the shortage of medical doctors rather than paying attention to the nursing workforce. Additionally, it was argued at the Council on Economic and Fiscal Policy, that the improvement of medical doctors' working environment had a negative impact on the nursing working environment because of a concern that nursing roles would be interpreted differently and expanded to take on some of the medical doctor's workload (Cabinet Office, 2009).

In July 2008, the Japanese Cabinet published an urgent measure for enhancing social security, the 'Five Security Plan' (Cabinet Office, 2008), to cover healthcare service, social

welfare, and the improvement of working conditions. There were two main drivers behind this publication. First an upcoming election and secondly anecdotal evidence about healthcare performance based on newspaper reports, editorial comment and Internet discussions (Kyodo Tsushin, 2008; Tsujihiro, 2008). In terms of the election, the government of Japan had been in power for more than 54 years²⁹ and in the face of falling public support, the Cabinet proposed changes in the social security system including healthcare. In the early 2000s concerns emerged in the press^{30,31} about the system of emergency care (e.g. in relation to maternal deaths) particularly in rural populations. The ‘Five Security Plan’ noted the shortage of medical doctors, a perceived unfairness in the distribution of healthcare, and scandals related to maternity care.

In the ‘Five Security Plan’, recruiting and retaining the nursing workforce, and encouraging inactive nurses’ re-entry to the nursing workforce were set as goals. Support for hospitals that introduced flexible nurse shift patterns and supporting day care services for female doctors and female nursing staff were also specified in this document. However, the ‘Five Security Plan’ was criticised as the Cabinet Office failed to show how the Security Plan was to be funded or implemented³². Additionally, it was also argued that the justification for publishing the ‘Five Security Plan was nothing urgent or new regarding healthcare and it was already covered by the ‘Vision of a Secured and Reliable Healthcare Service’ (Takagi, 2008).

The Security Plan had the following five focuses:

- Providing a high quality of healthcare and social care service to the elderly population,
- Improving the foundation of the emergency service, maternity care and paediatric care service,
- Establishing the foundation of the social care service that supports raising children,

²⁹ <http://www.jimin.jp/aboutus/history/1955-1956/index.html>

³⁰ http://dailynews.yahoo.co.jp/fc/domestic/emergency_transportation_acceptance_refusal/

³¹ <http://focus.allabout.co.jp/gm/gc/188727/?from=dailynews.yahoo.co.jp>

³² <http://diamond.jp/articles/-/3188?page=2>

<http://www.asahi.com/health/seiho/TKY200808260328.html>

- Improving the working environment for part-time and contract workers,
- Re-establishing public trust in the government social care service.

In 2009, the government changed, but the strategic direction of the previous policies remained.

In summary, it was clear that the government was trying to deliver a high quality of healthcare service to the population with limited resources (MHLW, 2003c) and the nursing workforce received attention as an adequate number of nursing staff was essential to establish the foundation of healthcare system like Scotland (MHLW, 2008). However, the nursing workforce did not get as much attention as medical doctors where there were issues of real shortages (MHLW, 2008).

In the next section, the legislation and regulation changes as a response to these policies are discussed and their effect on nursing.

Key Legislation Change in the Medical Care Fee Schedule for Remuneration

In the last 10 years, there have been two policy changes that brought a great impact on the nursing workforce. Firstly, there was a change in the medical treatment fee schedule for remuneration in 2006. Secondly, there were changes in ‘Public Health Nurses, Midwives, and Nurses Act’ and two changes in ‘Nurse Provision Act’ in 2009.

The legislation change in the medical treatment fee schedule for remuneration in 2006 brought a huge impact on the Japanese nursing workforce and nurse managers in hospitals (Okumura, 2006). As mentioned before (2.7.4), every two years there is a revision of the medical treatment fee schedule for remuneration. A regulation change in the ‘basic hospital fee’ made an impact on the nursing workforce (Central Social Insurance Medical Care Committee, 2005). The ‘basic hospital fee’ is a remuneration that is paid to hospitals per hospitalised patient and is categorised by the number of patients per nursing staff (RNs and ANs) who are in charge that day. To meet the criteria for each category, the hospital needs to employ a certain number of RNs. The intention of the government’s change in legislation was to improve the quality of nursing care provided in hospitals by encouraging the employment of more RNs and giving more remuneration to the hospitals with better nursing staffing levels (Kawaguchi, Yasukawa and Matsuda, 2008). This change became a

strong incentive for hospital managers to employ more nurses because meeting the 7:1 nurse staffing level that could bring direct benefits to the hospital (Table 2-12). In order to gain 7:1 approval, the hospital needed to employ at least 37 nursing staff (of which more than 70% were to RNs) per 50 patients.

Table 2-12: Example of nurse staffing by the basic hospitalisation fee category (Patients=50)

Category	Fee	Number of employed nursing staff	Portion of RNs among nursing staff	Night Shift		Day Shift	
				Number of nursing staff in charge	Number of patients per nursing staff	Number of nursing staff in charge	Number of patients per nursing staff
7:1	1555	37	70%>	5	10	12	4.2
10:1	1300	25	70%>	3	16.7	9	5.6
13:1	1092	20	70%>	3	16.7	6	8.3
15:1	954	17	40%>	2	25	6	8.3

Source: Reproduced from Japanese Nursing Association³³

The JNA conduct an annual survey to investigate the supply and demand among nursing staff in hospitals. A postal questionnaire was sent to all Directors of Nursing in all hospitals (n=9,024, response rate 35.6%) in Japan. According to the JNA's annual survey in 2007 (JNA, 2007c), a total of 330 hospitals (14.2%) out of all participating hospitals (n=3,210) achieved the criteria of seven patients per nursing staff in order to claim the highest remuneration from the government. Additionally, more than one third of all response hospitals (n=889, 38.7%) increased the nursing staffing to gain enhanced government funding (JNA, 2007c). Among hospitals that increased the nursing staffing level to gain added government funding, criteria for government approval was met in the following ways: (1) recruited more newly graduate registered nurses, (2) re-allocated the nursing staff to other wards within the hospital, (3) decreased the number of beds (JNA, 2007c).`

The average number of employed RQNs per hospital among the hospitals with increased nursing staffing levels was two times larger than the average number of employed RQNs per hospital (JNA, 2007c). It was also shown that a greater portion of hospitals with the 7:1 nursing staffing levels had their own programme to support newly qualified nurses compared to other participating hospitals. The positive impact of increased nurse staffing levels on healthcare included increased direct patient care hours, decreased extra working hours, and increased hours for supporting RQNs (JNA, 2007c).

³³ <http://www.nurse.or.jp/kakuho/pc/sagasu/basic.html>

However, it has to be noted that this legislation brought not only positive impacts on the healthcare but also negative impacts on healthcare. As a response to this legislative change, university hospitals recruited a greater number of RQNs compared to previous years in order to meet the criteria for 7:1 staffing level (Kyodo Tsushin, 2007). In particular, national funded university hospitals recruited an additional 2,212 RNs in 2007 compared to the year before the change. It was reported in one of the biggest university hospitals in Tokyo, that 40 % of the nursing staff were RQNs in some wards (Kyodo Tsushin, 2007). It was argued that the introduction of new nursing staffing level (7:1) lead to the uneven distribution of nursing staff and some middle-small size hospitals needed to close down due to the shortage of nursing staff³⁴ (Toyokeizai Newspaper, 2008). The Japan Medical Association conducted a survey to investigate the impact of legislative change in 2006 on the nursing workforce (Japan Medical Association, 2007a). A postal questionnaire was sent to 3185 hospitals in Japan. It was estimated that 20,000 beds could close due to establishing the introduced 7:1 nursing staffing level. However, there was not report to indicate the actual number of closed bed due to the revision.

In summary, the introduction of a 7:1 nursing staffing level encouraged hospitals to recruit more nurses, especially RQNs to meet the criteria for the government approval so that the hospitals could claim more remuneration. This resulted in a high demand for RQNs at the large teaching hospitals and difficulties for middle-small size hospitals to recruit RQNs. Despite the positive impact reported by JNA survey (2007), this researcher also felt as a RN at that time, negative impacts on nursing workforce due to this legislation change.

Key Legislative Change in 'Public Health Nurses, Midwives, and Nurses Act'

Other changes were contained in the 'Public Health Nurses, Midwives, and Nurses Act' and 'Nurse Provision Act' related to pre-registration programme and orientation training (MHLW, 2009f; MHLW, 2009c). New regulation applied to all RNs, hospitals and the government in terms of clinical training for RQNs. RQNs are required to seek the opportunity to attend any continuous training courses after registration. Hospitals were advised to establish a clinical training system for RQNs and to provide RNs opportunities to attend any training course (MHLW, 2009f). The government was given the responsibility to provide guidelines and regulation with financial support for the hospitals and RNs. The government introduced these legislative changes with the following comment. "There is a necessity that we need to provide a high quality of nursing care that

³⁴ <http://chiiki-iryo.net/modules/gnavi/index.php?cid=11&lid=106&page=print>

can respond to the increased demand of healthcare service due to the demographic change in Japanese population” (House of Councillors The National Diet of Japan, 2009). It was interpreted that this change would promote pre-registration nursing education at the university level as a response to the dramatic increase in the number of nursing universities (2.7.5) and increased demand of nursing care due to demographic changes (2.7.2) (JNA, 2009). Additionally it was also expected this legislative change would lead to improve quality of nursing care in the future.

In summary, recent legislation and regulation changes are focused on improving not only the quantity of the nursing staff, but also the quality of nursing staff (JNA, 2009). Despite the government intention to improve the quality of nursing care, there are mixed impact on nursing workforce and healthcare system and there was no study to examine the actual impact on the ward. Due to the huge impact on nursing workforce by the change in medical treatment fee schedule, RQNs started to gain more attention among stakeholders (JNA, 2007c). In the next section, the consensus conference report related to RQNs is discussed.

Key Government Report Related to Recently Qualified Nurses

Around the same time as the previous legislative changes, the high turnover rate among RQNs became a major issue (2.4.3). The clinical skills of RQNs and their pre-registration education became one of the key points to improve retention with RQNs (JNA, 2005).

A number of Consensus Conferences were held between 2003-2011 and related reports were published after the Consensus Conference. A Consensus conference is usually composed of members who are academics, clinical practitioner, managers, and professional union trustees. After the consensus conference meeting, a report is published with the direction of the future policies and possible legislation changes. However, it has to be noted that reports from consensus conferences do not have huge political power or influence on the operational management level unless the new policies or legislation changes are introduced. Nevertheless they are included in this literature review because they reflect the current issues in Japanese nursing and government funded projects are commissioned based on the reports.

During the period 2003-2011, there were more than 10 Consensus Conferences discussing either RQNs or pre-registration education (MHLW, 2003a; MHLW, 2003b; MHLW, 2004c). The four key reports related to RQNs are discussed in this section.

Firstly, in 2004, 'Report on the Advancement of Clinical Nursing Skills among RQNs' was published (MHLW, 2004c). Despite the fact that there had been always a discussion about the orientation training programme for RQNs, there were no documents that clearly stated the content and goals of the orientation training programme for RQNs. Thus this report was published to secure patient safety and improve the quality of clinical nursing practice. In the report, principles for clinical nursing education, the level of clinical nursing skill that should be met after the orientation training programme, the level of clinical nursing knowledge, and the right attitude as a RN were advised for RQNs.

The second report is 'Report on 'Act for Public Health Nurses, Midwives, and Nurses' to Secure Patient Safety' (MHLW, 2005b) based on a consensus conference and other previous government documents such as 'Vision of a Reformation in Healthcare Service Delivery System'. In this report, the quality of RQNs was discussed as one of the key factors to ensure patient safety. Several points were mentioned as issues related to recently qualified nurses: (1) high turnover rate among RQNs as one of the indicator that RQNs were not fit for clinical practice; (2) the lack of standardised orientation training programme for RQNs among employers; and (3) an increased number of medical adverse events reported by nursing staff with less than three years experience. It was emphasised that a governmental system for the orientation training for RQNs should be established as soon as possible.

The next report was 'Middle Term Report on the Quality of Nursing Care and Maintaining Nursing Workforce'(MHLW, 2009g) that emerged from a consensus conference held as a response to 'Vision of a secured and reliable healthcare service' to ensure that the nursing workforce was prepared to deliver what was needed for the public (MHLW, 2009g). In this report, it was suggested that there was a difference in nursing clinical practice between clinical nursing skills taught at the pre-registration course and the clinical nursing skills required at clinical practice. Even though the content and the goal of the orientation training programme was set in the previous report, 'Report on the advancement of clinical nursing skills among RQNs' by the government, the implementation was left to each hospital's discretion. The report concluded that the government should intervene on the

issue of the orientation training programme and pre-registration education to include on obligatory orientation training programme for RQNs.

Finally, as a response to the legislative change in Public Health Nurses, Midwives, and Nurses Act ' and 'Nurse Provision Act'(MHLW, 2009f) and the previous three reports (MHLW, 2004c; MHLW, 2005b; MHLW, 2009g), 'Report on the Orientation Training Programme for Recently Qualified Nurses' (2004) was published in 2011 (MHLW, 2011a). This report was published to promote the establishment of a clinical training system at every hospital where RQNs were employed. The guideline contains the basic policy of the orientation training programme, the recommended content of the programme, the level of clinical nursing skill, training system for the clinical educator, and evaluation system for the programme.

As can be noted, over the last few years, there were four reports emphasising the importance of RQNs and the orientation training system for RQNs (MHLW, 2004c; MHLW, 2005b; MHLW, 2009g; MHLW, 2011a). There is a clear message that it is important that RQNs have the ability to meet the level of clinical nursing skills and to provide the required nursing care to the public.

Summary

As can be seen from the preceding, the Japanese government was dealing with issues related to healthcare service. The nursing workforce was acknowledged as playing an important role in terms of delivering healthcare to the people.

2.7.8 Japanese Culture and Custom

In order to provide depth of information and insight regarding the background of where the study was conducted, a brief description of Japanese society and culture is described so that the context of the research settings could be understood. Firstly, brief description of Japanese culture is provided and then the differences in women's life between UK and Japan are discussed.

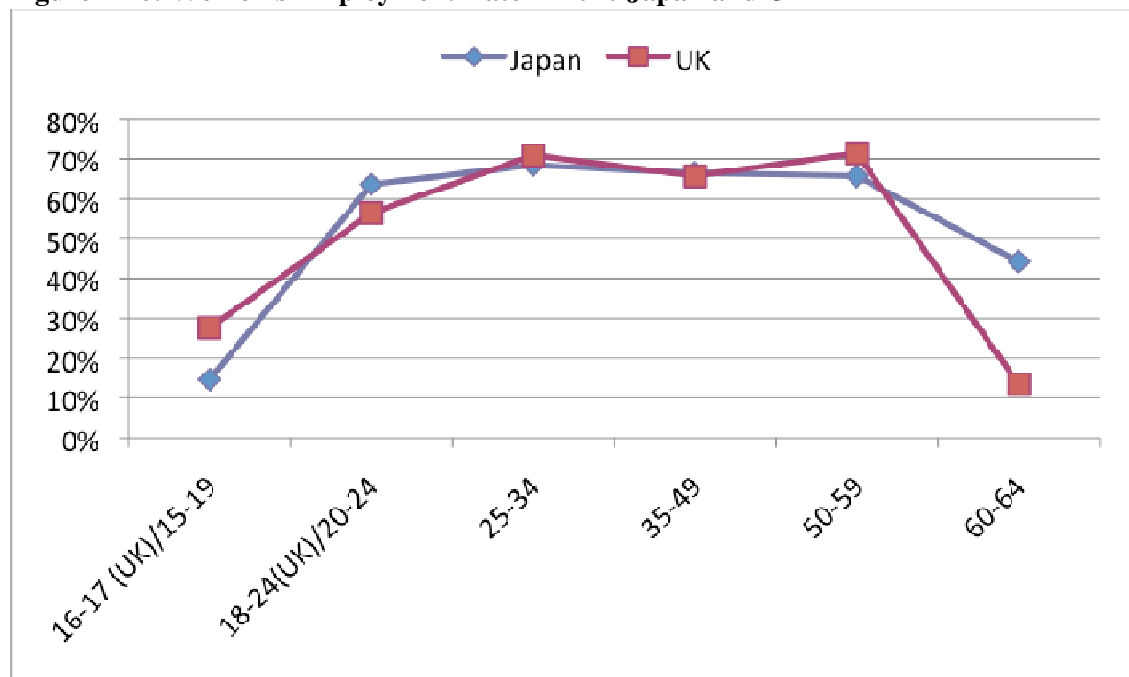
In order to explain Japanese culture and custom, several key concepts are often used. Japan developed a very unique morale and philosophy, where concepts are difficult to precisely translate into other languages, in particular Edo era. One of the most commonly understood

ideas is the sense of shame. Ruth Benedict, American anthropologist, described the difference of culture between western courtiers and Japan (Benedict, 1947). She analysed the values in Japanese culture and described Japanese culture as ‘shame culture’ and western culture as ‘guilt culture’. In western countries, people’s behaviour was ruled by the absolute moral standard of guilt whereas Japanese people’s behaviour was ruled by the external feeling of shame rather than internal principle (Benedict, 1947). Benedict analysed other common moral such as ‘*on*’ (debt of obligation) and ‘*giri*’ (moral obligation), which were developed under the feudal system (Sugiura and Gillespie, 2006). In Japan, the influence of the feudal system remains strong in the society. One of the good examples is the vertical society, which can be seen in some companies and government organisation. The vertical society values the order and relationship between people, who are in the different social positions. For example, people need to show their respect to superior people. ‘*Wa*’ is one of the other important key words to understand Japanese culture and custom. ‘*Wa*’ can be translated as ‘harmony’. In the first constitution of Japan, it was written “Harmony is to be valued”, which meant Japanese people value good manners and politeness in order to maintain the order and peace in the society. ‘*Wa*’ is often described as an example of the ‘collectivism’ of Japanese society. Despite these typical descriptions of Japanese split, it has to be noted that these are gradually changing as Japan has been internationalised and globalised.

A Comment on Women’s Working Life

Since nursing is female dominant, it is important to identify the unique aspect of Japanese women’s live. In the following sections, the distinctive feature of Japanese women’s life is described.

The following figure shows women’s employment rate in 2010 by age groups in Japan and the UK. Data were adjusted in order to compare the two different countries. As mentioned in the previous section (2.7.6) the distinctive feature of the Japanese women’s employment rate was ‘M-shaped’ (2.7.6) (Nakata and Miyazaki, 2008). In Japan, women’s employment rate decreases between the ages of 35-49 whereas UK women’s employment rate hits a peak in the ages of 50-59. The disparity can be explained by their behaviour after the marriage and childbirth. As mentioned before, it is still common among Japanese women that they quit their job at the time of marriage and childbirth. The differences between the UK and Japan in women’s employment cycle need to be noted as nursing is female dominant and their life cycle can affect their working behaviour especially in Japan.

Figure 2-16: Women's Employment Rate in 2010 Japan and UK

Source: Original diagram, compiled from UK: Labour Force Survey Employment Rates by Age 2010 Aug-Oct and Japan: Labour Force Survey-Long Term Series Data 2010

2.8 Summary of Literature Review

In this chapter, the current research findings regarding nursing and its relationship to the patients' outcome were presented. In the following topic, the issues related to the recently qualified nurses were presented in UK and Japan. Background of healthcare in Scotland and Japan and issues related to nursing healthcare and nursing were discussed along with the policies related to nursing workforce planning with a particular focus on recently qualified nurses.

2.9 Theoretical Framework of Policy Implementation

It is crucial to understand that policy implementation takes different paths and forms in different cultural and organisational settings (Van Meter and Van Horn, 1975). Implementation literally means 'carrying out', or 'completing' tasks which has been decided (Van Meter and Van Horn, 1975). Research on policy implementation has been discussed among social scientists for over the last 40 years. Since then, no theory of policy implementation has reached a general agreement (Schofield, 2001). Therefore, researchers continue to work from various theoretical perspectives and apply different variables to understand the findings of their research.

2.9.1 The First Generation

Policy implementation research emerged at the beginning of 1970s to react to concerns over the effectiveness of government programmes. Policy implementation research can be categorised into three generations: First generation policy implementation studies, which were predominant in the 1970s', focused on one single case and aimed to identify the issues in implementation and understanding influencing factors (Derthick, 1972; Pressman and Wildavsky, 1973; Murphy, 1973; Bardach, 1974). The achievement of first generation policy implementation studies was to raise the awareness of the issues in policy implementation.

2.9.2 The Second Generation

Second generation policy implementation research was predominantly conducted between late 1970s and early 1980s. Attention among researchers in the second generation was paid to describing and analysing the relationship between policy and practice in order to develop theoretical frameworks (Bermann, 1978; Hull and Hjern, 1982; Lipsky, 1980; Mazmanian and Sabatier, 1980; Van Meter and Van Horn, 1975). During second generation policy implementation studies, two major approaches emerged; 'top-down' and 'bottom-up'.

Top-Down Approach

The distinctive feature of the 'top-down' approach is that policy implementation starts with policy decisions, for example by a governmental authority and the processes of policy implementation follow. 'Top-down' approach scholars see policy formation and policy execution as distinctive actions and approach emphasises 'hierarchical control' (Schofield, 2001).

The initial attempt to present a model of policy implementation based on the 'top-down' approach was made by Van Meter and Van Horn (1975). In their model, six variables were identified which create the relationship between policy and implementation; 1) standards and objectives, 2) policy resources, 3) activities between organizations and executive activities, 4) specifications of administration, 4) economic, social, political parts, 6) enforcement trends. Additionally, Van Meter and Van Horn (1975) argue that the policy implementation process varies depending on the nature of policy to be carried out and the

types of policy. Classification of policies, based on the following characteristics was suggested by Van Meter and Van Horn (1975); 1) amount of change involved; 2) the extent to which there is goal consensus among the participants in the implementation process. The features of change are important as the implementation process is affected by the extent to which the policy diverges from the previous policies by the degree of organisational change required. The other important element of policy typology is the degree of consensus or conflict over the goals and objectives among participants. Van Meter and Van Horn (1975) argued that effective implementation depends on the factors contributing to the realisation of policy goals and objectives.

Mazmanian and Sabatier are acknowledged as representative ‘top-downers’ as their suggested framework was subjected to empirical implementation research. Mazmanian and Sabatier (1980) describe that policy implementation to carry out basic policy decisions, originally start from an authoritative decision and are incorporated in statute, or executive orders, or court decisions. Six conditions are identified by Mazmanian and Sabatier (1980), which are necessary for effective implementation; 1) clear and consistent objectives, 2) adequate casual theory, 3) implementation process structured to enhance compliance by implementers, 4) committed and skilful implementing officials, 5) support of interest groups and sovereigns, 6) changes in socio-economic conditions which do not substantially undermine political support or causal theory.

One of the fundamental criticisms of the ‘top-down’ approach is that they start from the decision-making, thus they tend to ignore other actors in policy (Schofield, 2001). In the ‘top-down’ approach, the key actor is the framer of the policy decision. Thus the other elements are seen as obstacles, which could lead to neglect of strategies and initiatives from other sources, such as private sector and local operational level (Bermann, 1978). Additionally, Barrett and Fudge (1981) argue that the distinction between policy formation and policy implementation is misleading and useless. For example, some organisations are involved in process, policy formation and implementation and it is difficult to isolate policy decisions.

Bottom-up Approach

As a response to the critique of the ‘top-down’ approach, the ‘bottom-up’ approach emerged with a different view towards policy implementation rather it highlights the view of the target groups and implementers (Berman, 1978; Hull and Hjern, 1982; Lipsky,

1980). Berman (1978) argued that policy implementation occurs at the two levels, macro and micro. At the macro implementation level, central decisions are made. At the micro implementation level, local organisations react to the policy and develop their own programmes and implement them. Elmore (1978) presented a model based on the ‘bottom-up’ approach where policy implementation is controlled by the policy itself rather than policy makers. Elmore (1978) argued that lack of consensus and commitment among implementers could lead to implementation failures. In other words, the most important feature of the implementation process is the individual’s motivation and interpersonal cooperation.

There are a couple of limitations to the ‘bottom-up’ approach. Firstly, it fails to recognise that the central policies are contingent factors to the local situation (Schofield, 2001). Another limitation is that it fails to start from an explicit theory of factors affecting its subject. The approaches rely on participants’ perspective and activities too much. Thus it is difficult to identify factors affecting their behaviours.

2.9.3 The Third Generation

A conflict exists between ‘top-down’ and ‘bottom-up’ approaches. Both approaches tend to highlight only a part of the whole policy implementation process. In order to respond to this conflict, the intention of third generation studies was to bridge the gap between the ‘top-down’ and the ‘bottom-up’ approach. From the third generation, the ‘synthesis’ approach emerged. Elmore (1985) combined his previous work (Elmore, 1978) with his new work. He emphasised the importance of political institutions, other available resources, and the ultimate goal of target groups. Googin, Bowman, Lester, and O’Toole (1990) accepted the ‘top-down’ perspective that centrally defined policies are implemented by lower level implementers. However, their concept of policy implementation includes the idea that the outcomes of policy implementations are the results of complicated negotiations between central authorities and implementers. The distinctive innovations of third generation policy implementation studies are a focus on conceptualisation of the implementation process and the development of models that include the aspect of central authority and local autonomy (Schofield, 2001).

2.9.4 Theoretical Framework of this Study

The aim of this study focuses not only policy implementation, but also policy itself and policy outcomes. In the previous sections, the theoretical grounding to describe the situations of two countries related to nursing workforce policies targeted at RQNs was provided. The theoretical framework with the perspectives from both ‘top-down’ and ‘bottom-up’ approaches would fit in well with the concept and the aim of this study is to provide the researcher with two perspectives to review the policy implementation process.

2.10 Research Questions

Following the review of the literature and the identification of the gap in knowledge, this study set out the following questions. However, it has to be noted that research question 1 was mostly answered during the literature review and similarities and differences are discussed later in the chapter 7.

1. What government-driven policy exists to maintain the recently qualified nursing workforce in Scotland and Japan?
2. To what extent are registered nurses in clinical practice aware of these policies?
3. What are the responses of clinical practice to these workforce policies?
4. Do nurse managers and RQNs have issues and/or concerns related to these workforce policies?
5. Can an understanding of questions 1-4 suggest how policies related to RQNs could be better developed and implemented?

In the next chapter, literature pertaining to the selected methods in this study is presented.

Chapter 3 Literature Pertaining to the Methods

3.1 Introduction

To answer the research questions, a case study and a mixed methods research approach were applied within this study. Face-to-face, individual, semi-structured interviews were chosen to explore the perceptions and general opinions on government initiatives related to recently qualified nurses. Validated and reliable questionnaires were adapted and developed to investigate the perceptions of workplace change among RNs, the experiences of being a recently qualified nurse and the nursing practice environment. In this chapter, issues pertaining to the selected methods are discussed, including case study, mixed methods research, interviews, questionnaires, translation, ethical issues and study rigor.

3.2 The Case Study

Case studies have been used often to widen understanding of individuals, groups, organisations and socially and politically related phenomena within various disciplinary areas such as psychology, sociology, business, economics and medicine (Yin, 2009). Within these disciplinary areas, the desire to understand complex social phenomena brings forth the distinctive needs for the case study (Yin, 2009).

3.2.1 Justification of the Case Study Approach Taken in this Study

Case studies have distinctive advantages and also disadvantages. The case study research approach was utilised in this study for the following reason: this study examines the contemporary situation regarding government policies related to recently qualified nurses in Scotland and Japan. Additionally, the aim of this study is not to generalise the findings and results or develop a theory, but to gain an understanding of the situation in Scotland and Japan in terms of the impact of government policies related to recently qualified nurses. These are some of the advantages of applying case study research in answering the research questions, even though several research questions are not preferred for the application of the case study approach.

3.2.2 A Historical Background to Case Study Research

Case study research was significantly developed in the 1960s and 1970s in the USA and the UK within educational and evaluation research as an alternative approach to providing further understanding of phenomena and to explain the failure or success of a particular programme within a social and political context (Simons, 2009). Since then, case study research has become widely accepted as a research approach for evaluating particular phenomena or systems and also providing a holistic understanding within a real life context (Simons, 2009). Thus, the term 'case study' is used for a variety of research approaches, both quantitative and qualitative, within various research disciplines such as sociology, education, psychology and business (Holloway and Wheeler, 2002). Case study research has been acknowledged as one of the most popular research approaches among sociologists and also other areas of social inquiry. Nursing is not an exception given the introduction of case study research in the nursing research field in the 1970s when case study research became more common (Burns and Grove, 2005; Anthony and Jack, 2009).

As mentioned before, case study research is widely applied in nursing research. An integrative review was conducted to critically analyse the use of case study methodology in nursing research (Anthony and Jack, 2009). They identified why, how and where case study methodology, with a particular focus on qualitative studies, had been used in nursing research. An integrative literature review was conducted with two or more search strategies. The review sample was generated from six different databases from January 2006 to July 2007. Additionally, hand searching was also applied. A total of 226 papers emerged as a provisional sample and 42 papers were identified as a sample for the analysis. Literature was limited to English, nurse lead author and empirical literature. It was concluded that the 'qualitative case study' was used globally to describe, explore and understand or evaluate phenomena, including the experience and perceptions of individuals within a context of real life. The flexibility and capacity of case study research was also highlighted. However, several issues were also pointed out such as the lack of a standard concept of case study and lack of uniformity in terminology, identified as potential challenges for use in nursing (Gomm, Hammersley and Foster, 2004; Anthony and Jack, 2009). In the next few paragraphs, the concept of case study research, including a definition, types of case study research and challenges of this type of research are discussed.

3.2.3 Definition of a Case Study

Despite the wide usage of the term ‘case study’, there is confusion about the name, nature and use of the term (Anthony and Jack, 2009). As previously noted, different meanings in different disciplines makes defining a case study problematic (Stake, 2000; Gomm et al., 2004). Several approaches have been taken to characterise the case study approach. Gomm et al. (2004) characterised a case study approach based on several features such as the number of cases to be studied, the amount of detailed information to be collected, the way data were analysed and the degree of control over the variables and issues. Others tried to identify what is not case study. Yin (2009) stated that ‘case study’ is NOT equivalent to observational studies, is NOT a simple, pre-experimental study and IS different to casework.

Stake defined a case study as ‘the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances’ (Stake, 2000). He pays attention to the more qualitative exploration of the case study rather than quantitative exploration which emphasises the set of the numbers on the case and a collection of descriptive variables, which is commonly applied in medicine and business studies. Although his definition focused on qualitative exploration, he emphasised that a case study is not synonymous with qualitative methods. While a case study is often employed with qualitative methods, methodological choice does not define case study. Importantly, Stake states that a case study is defined by a choice of what is to be studied rather than methodological choice (Stake, 1995; Stake, 2000). Simons (2009) compared case study definitions between several authors. He indicated that there are differences on case study definition and a different emphasis is placed on them by each author even though there was a common understanding; that is, a case study is a study to investigate a complex situation and phenomena within a real life context. For example, MacDonald and Walker (1975) emphasised the possibility of generalisation of the particular that can provide the universal significant insights as a characteristics of case study whereas Merriam (1998) focused more on the feature of reasoning the phenomena within the context of real life. However, both their definitions of case study had one thing in common; studying the phenomenon within a real life context (Simons, 2009). These discussions lead again to the difficulty of defining the case study, yet the common understanding of the main feature of case study is to understand the phenomena within the real life context.

3.2.4 Use of the Case Study Approach in Health Service and Policy Research

Yin (2009) discussed the use of a case study approach within the social science context by comparing its features to other research approaches; experiment, survey and histories (Yin, 2009). The detailed explanation of each research approach within the social science context is not addressed in this section; however the use of the case study method is discussed.

Historically, case study was applied at the exploratory phase of investigation and others, such as survey and history, are applied for the descriptive phase and the explanatory phase. However, it was claimed that each approach could be used for all these purposes; exploratory, descriptive and explanatory: it could be an exploratory case study, descriptive case study or explanatory case study (Yin, 2009). What distinguishes the case study from other research approaches is not the purpose of study, but the types of research questions and the degree of focus on the contemporary event, and the requirement for controlling behavioural events.

Generally, a case study is likely to be the preferred research strategy when the research questions are starting with 'how' and 'why' (Yin, 2009). These questions are more explanatory and case study approaches can be used to answer these kind of questions, such as 'how did the community overcome the negative impact of introducing new industry into the east side of the area?' When the research questions start with 'what', they can be answered also by the case study approach, such as 'what can be learned from a study of magnet hospital?' However, other different types of research questions starting with 'what' that ask the degree of something such as a different form of 'how much' or 'how many', might be more likely to be answered by the survey approach. Similarly, identifying the outcome, fact or the numbers, such as 'what is the outcome of a new governmental programme?' could be answered by survey or examining the data without doing a case study. However, it would be needed if the study also intends to identify the reasons or the insight of the phenomena. Importantly, it has to be noted that identification of research questions cannot guide the researcher as to the most appropriate research approaches, but can provide important clues and directions for deciding the most appropriate approach to be used for the study.

The degree of control over an event or phenomenon is distinguishable from other approaches, as seen in experimental research. This is the second condition when to apply

the case study approach. Usually the case study approach cannot manipulate the relevant event and is unlikely to have control over the event or phenomenon. In addition, the case study approach has the ability to deal with various sources, documents, interviews, artefacts and observations.

The other condition of case study research is the degree of focus on the contemporary events. This method can focus on the contemporary events or on an event in the past.

It was also suggested that applying case study approach is particularly suited for health service systems and policy researches due to the strength of case study approached such as being able to collect in-depth data on organisational process, impact of policy changes , and different interested parties that are involved policy implementation (Keen, 2006).

To summarise, the case study approach has distinctive advantages in particular situations when the research question starts with ‘how’ or ‘why’ and is asking about the contemporary event when the researcher has little or no control. In addition, it has to be noted that the case study method can also be applied to a study dealing with concurrent events or phenomena with no control over them.

In this study, all research questions did not fit in to one of the above conditions where research questions usually start with ‘why’ or ‘how’. However, the researcher decided to apply the case study approach for the following reasons:

- The researcher intended to investigate the policy context and its impact on the clinical practice.
- The researcher did not have any control over the relevant event, such as policy implementation and policy development process.
- This study focused on contemporary events.
- Research questions 2 – 4 could be rephrased to ‘How has the situation changed over the last couple of years due to the policy?’

3.2.5 Types of Case Studies

Case is ‘a bounded system’, drawing attention to it as an object rather than a process and it has been categorised into three different types of case studies according to the case to be studied (Stake, 1995; Stake, 2000). Intrinsic case study is when a case is studied for the intrinsic interest and the researcher would like to have better understanding of this particular case. Therefore, study is not undertaken because it illustrates or explains the particular characteristic or issues. Instrumental case study is when the case is studied to explore the insight into it or the issues, and to redraw a generalisation. Here the case itself is a secondary interest and adds a further understanding of something else, not the case itself. Collective case study is when several cases are used to investigate the phenomenon, population and/or general condition. Although Stake (2000) made the distinction between these three kinds of cases, his intention was not to state the usefulness of sorting out the case study into three categories. His intention was to highlight the differences of methods in research when using each approach, depending on their interests.

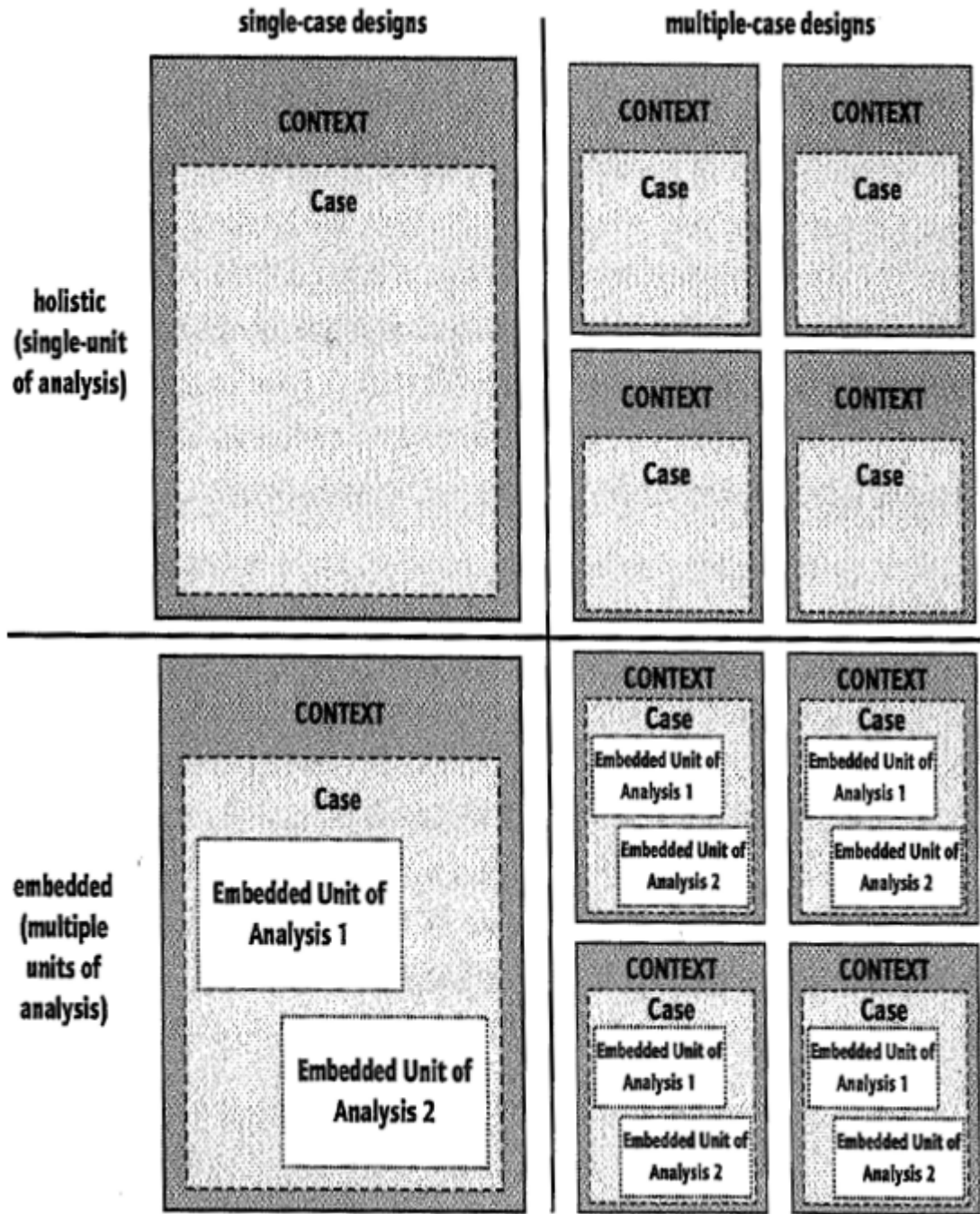
Different types of case study approach were proposed by Yin (2003): exploratory, explanatory and descriptive. Exploratory case study is aimed at defining the questions and hypothesis of a subsequent study and to debate the value of further study. Explanatory is to explain aspects and case-effect relationship identified by the descriptive research. Descriptive case study provides a complete description of the phenomenon within the context.

In this study, the researcher’s intention was to understand the situation in Scotland and Japan of the government policies related to recently qualified nurses (RQNs). Thus, this study would be categorised as an intrinsic case study by Stake’s categorisation.

3.2.6 Design of Case Study

There are four different case study designs (Yin, 2009). The following figure shows the four study designs.

Figure 3-1: Basic Types of Designs for Case Study



Source: Reproduced from Yin (2009)

The first decision the researcher needs to make in designing a case study is whether it is a single case study or multiple case studies (Luck, Jackson and Usher, 2006; Yin, 2009). Yin (2009) indicates that single case study is appropriate if the case has one of the following rationales: the first reasoning is when the case is a critical case to test a well-formulated theory because this case can fit in with the conditions and circumstances which are specified in the theory. A second rationale is when the case is extremely rare or unique so that it is worth documenting and analysing, such as unique clinical symptoms or diseases. The third rationale is when the case is a representative or typical case. The purpose of

investigating this type of case is to apprehend the conditions and circumstances in a 'typical' situation. The findings are expected to provide more information about these 'typical' situations. The fourth rationale of single case study is when the case is revelatory. This is the only case when the researcher previously has no access to the phenomenon or subject for the scientific investigation. The last rationale for single case study is when the case is longitudinal and the case is studied several times over different time periods.

When one study contains more than a single case, multiple case study design is applied. There is a different view towards the methodological framework in single case study and multiple case study (Yin, 2009). It is generally acknowledged that multiple case study is a variant of a single case study. However, in different fields such as anthropology and political science, single case study and multiple case study are considered to have different methodologies and have developed their own framework for conducting the case study (Yin, 2009). Multiple case study has both advantages and disadvantages: one of the features in multiple case study is that the findings and results are considered stronger and more robust, even though the rationale for single case study cannot be satisfied by multiple case study (Yin, 2009). In addition, multiple case study usually requires more time and resources. The other factor that a multiple case study needs to allow for is that 'replication' could give the researchers difficulties in conducting multiple case study (Yin, 2009). This 'replication' does not mean multiple case is the equivalent of multiple respondents in a survey. The idea of 'replication' is similar to multiple experiments, which is that similar results or contrasting results are expected at the end of the investigation from the cases (Yin, 2009). Thus, each case should be carefully selected so that it can predict similar results or contrasting results under the development of rich theoretical framework.

The second decision the researcher needs to make on designing a case study is how many units of analysis are involved in the study. This decision leads the research to the holistic case study design or embedded case study design. When the case involves several units of analysis, for instance, the case is about hospital organisation, the analysis might involve the structure of wards, clinical service itself and staff employed by the hospital, it is an embedded case study. Holistic case study is only when the researcher examines the whole nature of a phenomenon, event or organisation, not the specific aspect of the phenomenon.

Even though there were two cases, Scotland and Japan, the researcher decided to identify this study as two single case studies with multiple units of analysis conducted in two countries for the following reasons: 1) each case is a unique case where each country has a

unique situation related to recently qualified nurses (RQNs); 2) the case included government policies, hospitals, wards and RQNs and included multiple units of analysis.

3.3 Mixed Methods Research Approach

Mixed methods (methodological triangulation) research is acknowledged as a research design that can enhance the validity of study by combining two or more research approaches and can provide a better understanding of research problems (Polit and Beck, 2004). Combining qualitative and quantitative approaches has become more common without a doubt. Some researchers see three distinctive research approaches: qualitative, quantitative and mixed methods or multi-methods or mixed methodology (Bryman, 2006). Mixed methods research has been defined as “a research design with philosophical assumption as well as methods of inquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative approaches in many phases in the research process. As a method, it focuses on collecting, analysing, and mixing both qualitative and quantitative data in a single study or series of studies” (Creswell and Plano-Clark, 2007).

Combining quantitative and qualitative research methods created controversial arguments in the nursing research field. It was argued that mixed methods research strengthened the validity of a study: in a way it may compensate for design weaknesses and give researchers different aspects of the reality and more understanding of the research problem than the single approach itself (Polit and Beck, 2004; Creswell and Plano-Clark, 2007). The argument of the weakness in each approach goes that quantitative research cannot provide deeper understanding of the content of people’s voices and that qualitative research is insufficient because the interpretation made by the researchers is biased and these difficulties are generalised in the findings (Creswell and Plano-Clark, 2007). Despite the popularisation of mixed methods research, it has to be noted that combining the two research methods does not counterbalance poor design research (Burns and Grove, 2005).

In addition to the above, several advantages are noted as follows (Polit and Beck, 2004; Creswell and Plano-Clark, 2007): firstly, applying mixed methods has the potential to enhance the validity of the study when the models or hypothesis are supported by multiple and complementary data. Secondly, combining quantitative and qualitative approaches allow the researcher to have alternative ways of viewing and interpreting the world which can reflect and reveal the different aspects of reality. Thirdly, the other advantage is the

possibility of creating a new front line when researchers find inconsistency in their findings between quantitative and qualitative data.

On the other hand, several disadvantages exist: the potential incompatibility of two different research methods was claimed as a disadvantage because the views of two research methods were different (Burns and Grove, 2005). The difficulty of designing mixed methods was not commonly acknowledged among researchers. It was suggested that mixed methods research requires researchers to have the ability to handle complex design, measurement, data collection procedures and volumes of data (Polit and Beck, 2004).

Taking these advantages and disadvantages into consideration, mixed methods research can be applied for a wide range of purposes: instrument development, hypothesis generation, understanding the relationships and correlation, building theories and refining theories (Polit and Beck, 2004).

3.4 Justification of Cross-cultural (International Comparison) Study

Japan and Scotland were chosen as countries to compare policies, implementation and the impact of policies regarding nursing workforce planning, related to recently qualified nurses. There are two factors to justify the choice of Japan and Scotland as comparison countries, as follows below.

Firstly, similarities in both countries exist. Despite the fact there are differences in terms of health care system, politics, economic situation and sociocultural background, these countries have several similarities in terms of healthcare structure and issues related to providing health care, such as increasing medical costs, an ageing population and inequality in health care distribution (2.6 and 2.7). For example, Japan has a similar health system to the NHS in terms of target population and funding. The Japanese health system provides total health insurance coverage for the entire population. Under the system, all citizens subscribe to the public health insurance system and pay a fixed premium so that they can receive medical services with minimum burden. The majority of health services are provided under the health insurance system. The funds of the health care system come from tax and insurance. Increasing medical costs can make a significant impact on the government's finance situation and also on government health policy. Thus, these factors allowed the chief investigator to compare results and findings from studies conducted in Scotland and Japan.

Secondly, the importance of conducting cross-cultural nursing studies has been acknowledged (Suhonen, Saarikoski and Leino-Kilpi, 2009). Cross-cultural comparison studies have been applied between various countries, including Japan (Bradbury-Jones, Irvine and Sambrook, 2007; Irvine, Lloyd, Jones, Allsup, Kakehashi, Ogi and Okuyama, 2007). It is important to understand health and nursing problems on an international basis since health care systems and organisations have been restructured to improve health and sustain the quality of health services within limited resources in developed countries (OECD, 2004; Suhonen et al., 2009). The literature suggests that policy comparison may give us more understanding of similarities and differences and may suggest new approaches to develop health policy (Blank and Burau, 2004; Attree et al.). Thus, this study aimed to identify similarities and differences in government policies regarding the nursing workforce and their impact on the critical care nursing workforce, and allowed comparisons to be made.

3.5 Translation

When conducting international study or cross-cultural study researchers may encounter challenges related to translation of data collection instrument and findings (Suhonen et al., 2009). Translation is not a simple matter of the language of the participants, but also the culture validation within the context of the data collection tool. The process of translating a data collection tool is not easy. The importance of translation within the context of cultural validation has been highlighted in various cross-cultural and international nursing studies (Jones, Lee, Phillips, Zhang and Jaceldo, 2001; Bradbury-Jones et al., 2007; Cha, Kim and Erlen, 2007), as well as the difficulties of translation.

The goal of translation is to achieve the equivalence between two different languages. The quality of a bilingual translator is essential for the rigor of the study (Im, Page, Lin, Tsai and Cheng, 2004). Brislin's back-translation model for translating the data collection instrument has been applied in many studies and discussed (Brislin, Lonner and Thorndike, 1973; Jones et al., 2001; Lee, Li, Arai and Puntillo, 2009). Brislin's model was used for preparing reliable and valid data collection tools for cross-cultural research in this study. The processes of Brislin's model are follows:

- A bilingual person translates the instrument from original language (in this study, English) to a target language (in this study, Japanese).

- Then another bilingual person translates the translated document from target language to original language.
- Both original version of the document and back-translated document are compared to see if they are identical or not.
- If there is error in meaning, the same procedure will be undertaken again by a different bilingual translator till there is no error between the two documents.

Brislin suggested that there are several factors related to good translation which can establish the equivalence of meaning between original, target and back-translated versions. The factors involve sharing a set of rules for translating certain non-equivalent words and phrases, and retaining the original grammatical structure and form. However, the translators should be aware that retaining grammatical structure is only needed for back-translation, not for the purpose of asking questions of participants who are monolingual since grammatical structure is different from language to language and it may cause misunderstanding of the sentence (Brislin et al., 1973).

In order to ensure the quality of translation, and validation of the translated instrument, a combined translation technique was introduced by Jones et al. (Jones et al., 2001). They combined back-translation and bilingual techniques suggested by Brislin (1970). Firstly, two bilinguals translate the documents from the original to the target language. Two translated target language versions of the documents are then back-translated by another two bilinguals. After discussion regarding the differences between the two versions with a team of bilinguals, the newly translated target version is developed. Two other bilinguals do back-translations of the new version and a group discussion is held following a development of the second version of target language instrument. Lastly, they test the reliability and equivalence of the original and target language versions.

The weakness of these models should be noted. Regarding Brislin's model, the researchers cannot estimate the number of bilingual translators needed, accessibility or availability of translators who have the relevant background of language, culture and areas of study (Cha et al., 2007). The other model by Jones et al. requires a greater number of bilingual people. In addition, acculturation of bilingual people was identified as a weakness because they may respond differently to the monolingual people (Jones et al., 2001). The other concern was that the bigger the difference on language structure between the original language and

target language, or the more metaphorical expressions used, the bigger the problem the translated documents faced (Brislin et al., 1973; Jones et al., 2001; Lee et al., 2009).

To overcome these issues and ensure quality of translation and validation of translation instruments, various approaches are reported among nursing researchers, including combining the translation techniques such as back-translation and monolingual and/or bilingual testing (Maneesriwongul and Dixon, 2004). In this study, the back-translation of data collection instruments and pre-testing the Japanese version were conducted (4.5.1 and 4.5.8) after consideration of the availability of bilinguals and time management.

3.6 Interviews

Interviews are often acknowledged as the most commonly applied data collection method within qualitative research (Holloway and Wheeler, 2002; Gillham, 2005; Taylor, 2005) and they aim to understand and capture the world from the participant's perspective; their feelings, experiences and thoughts. Interviews are acknowledged as one of the most important information sources for the case study data collection (Yin, 2009). Face-to-face, semi-structured interviews were chosen as the qualitative data collection method in this study. For the next following sections, definition of interview, interview methods, advantages and disadvantages of the interview as well as interview skills are discussed.

3.6.1 Justification for Using Semi-structured Individual Interviews

In this study, the semi-structured individual interview was applied to gain in depth data on an individual basis. Individual interviews allow the researcher and the participant to have more privacy so that the participants can express their perceptions and experiences. Additionally, semi-structured interviews allow the researcher a certain level of control over collecting data during interviews and at the same time to gain expanded data. Individual flexibility of the individual interview was taken into consideration during the decision-making process, in terms of scheduling the interviews.

3.6.2 Definition of Interviews and Different Types of Interviews

An Interview has been defined as a 'conversation with a purpose' (Burgess, 1984). Although interviews often contain informal questions and the tone of the interview is generally conversational research, interviews are more than conversation and the questions

asked in the interview have more rules than a conversation (Holloway and Wheeler, 2002; Taylor, 2005). The researcher usually has an interview guide which outlines the themes, topics and areas to be explored during the interview. However, the interview guide will only guide the participant to explore their experiences, feelings, thoughts and perspectives, rather than guide the researcher to have control over the interview to collect information that they need. The flexibility and adaptability of interviews are also often stressed (Gillham, 2005; Taylor, 2005). The main features of interviews are identified as follows:

- Participants are able to determine their own answers with their own words to the questions or topics asked (Gillham, 2005).
- It is a responsive and interactive relationship between participant and researcher with some degree of ‘adjustment’, clarification and exploration (Burns and Grove, 2005).
- Even though the questions asked are ‘natural’ in the real life setting, the context of the interview has structure and purpose (Gillham, 2005).

Although most health care professionals, including nurses, are familiar with the process of clinical information gathering interviews and are skilled at this, they need to be aware that the interview as a qualitative data collection method is different (Holloway and Wheeler, 2002).

As mentioned before, interviews are the most commonly used data collection method (Polit and Beck, 2004). Interview styles vary. Three main interview styles are discussed in the next section.

Semi-structured Interview

When the researcher is aware of the questions to ask, but not able to predict the answer to the questions, the researcher needs to have more control over the content and structure of the interview (Gillham, 2005; Taylor, 2005). In this case, the semi-structured interview is commonly used as the qualitative data collection method, where the researcher needs to prepare an interview guide with the topic and areas which need to be covered in the interview (Polit and Beck, 2004). The interview guide enables the researcher to obtain similar types of data from each participant and also the required information because of its

flexibility and well balanced structure; all of which can be prepared in advance (Burns and Grove, 2005; Gillham, 2005). The main features of a semi-structured interview are as follows:

- The same questions are asked to obtain similar types of data which cover the theme and area to be investigated (Polit and Beck, 2004; Gillham, 2005).
- Probes are used to elicit more detailed information (Burns and Grove, 2005).
- The type, form and order of questions need to be carefully developed in logical sequence, such as chronologically, or general to the specific (Burns and Grove, 2005).
- The direction or character of the answer to the question is open, even though the participant has less responsibility and control over the structure and content of the interview compared to the unstructured interview.

Unstructured Interview

The main feature of the unstructured interview is that gives the participant more control over the content of the interview and more responsibility for determining the direction and structure of interview (Burns and Grove, 2005; Gillham, 2005). Thus, it is important that the researcher lets the participant tell their stories without interruption. Unstructured interviews are usually utilised in the following cases:

- When the researcher is unsure about the research topic, and is trying to identify the problem to be investigated (Gillham, 2005).
- Where the participant is constrained or inhibited by being interviewed with other more structured approaches (Gillham, 2005).
- When the researcher's aim is to explore the aspect of an individual's life or other significant themes that can be only obtained by giving the participant more allowance in structure and content of the interview (Gillham, 2005).

Due to the features above, the unstructured interview is usually applied in phenomenology, ethnography and grounded theory (Polit and Beck, 2004).

Structured Interview

The structured interview is sometimes referred to as a quantitative data collection method because of the nature of the data which can be obtained (Burns and Grove, 2005; Taylor, 2005). More control over the context and structure of the interview is given to the researcher. Questions to be asked need to be planned well in advance, and should be asked precisely as it has been designed (Burns and Grove, 2005). The participant usually has a specific range of answers, which is similar to the features of a questionnaire (which will be discussed later in this chapter). This approach is often used in a marketing research or social survey (Gillham, 2005).

Other Types of Interview

Although interviews involve verbal communication and interactive relationships between the researcher and the participants, this does not mean interviews are always face-to-face. There are new styles of interviews as technology has been developed, such as telephone interviews and e-mail interviews. The biggest features of these distance approaches are the low cost and the great degree of 'distance' to the researcher as well as being 'anonymous' (Gillham, 2005). However, this brings an argument that these interview techniques, which restrain interactive relationships between the researcher and the participants, should not be referred to as interviews.

3.6.3 Developing an Interview Guide

A key factor of interviewing is flexibility (King and Horrocks, 2010). A semi-structured interview guide provides the outline of the main topics of the research, but it still leaves the flexibility in phrasing and the order of questions. Additionally, the participants still are able to lead the interview in an unanticipated direction within the context of the main topics of research. King and Horrocks (2008) suggested three sources to identify the topics to be included in the interview guide: personal experiences of the research area, research literature on the same subject and informal preliminary work on the subject area. The difficulty of developing the interview guide is identified as balancing the degree of comprehensiveness of the topics covered in the interview guide. The disadvantage of the comprehensive interview guide is that there is possibility to lose some of the perspectives or issues that are not unanticipated, but that are important to the research topics. On the other hand, the disadvantage of a minimalistic interview guide is failing to address

important issues. In order to avoid confronting these disadvantages, the interview guide should reflect the aim of the research and the methodological position. For example, a narrative study would use a more minimalistic guide.

3.6.4 Conducting Effective Interviews

In order to conduct and produce good research based on interviews, not only research design and methodological position, but also conducting interviews effectively is crucial (King and Horrocks, 2010). Essential factors of conducting effective interviews are discussed in this section.

Firstly, the interview setting can influence the procedure of the interviews. A comfortable, private and quiet environment are the three vital elements for the suitable interview location (Burns and Grove, 2005; King and Horrocks, 2010). A comfortable environment refers not only to physical comfort, but also psychological comfort so that the participants can express themselves freely and provide natural well-developed answers to the questions. Privacy is important to avoid the danger of interrupted or overlooked during the interview, which relates to the psychological comfort. Having a quiet environment is important not only for providing a relaxing environment, but also reducing the risk of having problems with recordings.

Secondly, building a good researcher and participant relationship is identified as one of the crucial elements. The relationship between the researcher and the participant is distinguished between the quantitative and qualitative research as the qualitative research involves interactions with the participants such as interviewing (Burns and Grove, 2005). Researchers need to be aware that they and the participants influence each other to some degree during the study process. In addition, the relationship needs to be based on mutual respect and on an equal position even though being in a relationship of complete equality with the participant is sometimes difficult. 'Rapport' is used to refer to the good relationship between the researcher and the participants. 'Rapport' is based on trust between the researcher and the participants, and about enabling the participants to feel comfortable to speak openly (King and Horrocks, 2010), not about carrying favour with the participants. Thus, it is important for the researcher to empower the participants by listening and showing interest in the participants' perspectives.

The last factor is interview skills. Interviewing requires the researcher to develop interview skills prior to initiating a study (Burns and Grove, 2005). How to elicit a higher quality of data very much depends on how skilled the interviewer is. The skilled interviewer knows when and how to intervene, when and how to direct to another topic, how to manage non-verbal communication and how to manage difficult interviews such as dealing with sensitive topics. Conducting a pilot interview with individuals who meet the sampling criteria is suggested to identify the issues related to the interviews (Holloway and Wheeler, 2002).

3.6.5 Field Notes

Field notes are a broad, analytic and interpretive way to record the information and also synthesise and understand the data. Field notes have two perspectives; descriptive and reflective. Descriptive notes contain descriptive and objective information about the observed events and conversation. Reflective notes are for the researcher to reflect on their personal experiences during the data collection period. In this study, field notes were taken to gain objective (length of interviews, the interview location, etc) and subjective data.

3.7 Data Analysis of Interview data

Data analysis is a process of organising and providing structure to and extracting meaning from research data (Polit and Beck, 2004). The purpose is the same whether the research data are qualitative or quantitative. However, the qualitative data analysis process is different from the quantitative and is very challenging. Firstly, the lack of universal rules for qualitative data analysis and presentation make it difficult to explain how to do data analysis and how to present findings (Polit and Beck, 2004). Secondly, qualitative data analysis requires the researcher to undertake a great amount of work because of the number of pages of data that need to be organised, integrated and interpreted. The last challenge is to condense the data for reporting the findings which should still maintain the richness and value of the original data (Polit and Beck, 2004). In addition, selection of data analysis methods is essential to establish the study rigor and it should be based on the data collection methods used in the study (Polit and Beck, 2004). Thus, it is crucial to select the most appropriate data analysis method and present the process of data analysis for establishing the study rigor. There are a variety of analysis procedures based on different traditions and paradigms (Burns and Grove, 2005). However, some studies are not based on a formal tradition or paradigm, or are not characterised and described in a particular

disciplinary framework (Polit and Beck, 2004). With these cases, the data analysis methods are often stated as content analysis or qualitative content analysis (Polit and Beck, 2004). Although the researcher decided to apply a case study approach, this study was difficult to characterise or describe as belonging to one tradition or discipline. In this study qualitative content data analysis was applied to the interview data to understand the meaning of the context. In the following paragraphs, the conceptual framework for qualitative content analysis is discussed.

3.7.1 Background of Content Analysis

Even though content analysis has appeared in English literature for only about 70 years, the history of content analysis can be traced back to in 17th century (Krippendorff, 2004). It has been widely used in health care studies, and more than 4,000 articles have been published with content analysis as a subject heading within the last 20 years (Hsieh and Shannon, 2005). Initially, researchers used content analysis as qualitative and quantitative research approaches in their studies. However, later on content analysis was used in more quantitative research such as media research and newspapers (Krippendorff, 2004). Within this quantitative content analysis, text data were coded in explicit categories and reported with statistics. This approach was often referred to as quantitative analysis of qualitative data. More recently, the position of content analysis as qualitative data analysis has been established especially in nursing studies.

The distinguishing feature of content analysis, both quantitative and qualitative, is the use of a consistent set of codes to classify data segments that contain similar meanings and the goal of content analysis is to provide knowledge and understanding of the phenomenon (Morgan, 1993). Although some researchers regard content analysis as a quantitative analysis approach because it contains counting, many qualitative researchers who conduct studies which claim no particular disciplinary tradition, simply state the data analysis approach method as qualitative content analysis or content analysis because of its flexibility in study design and content sensitive methods (Elo and Kyngas, 2008). For these reasons, content analysis has been widely accepted and established in health research and nursing studies (Elo and Kyngas, 2008). However, it is often argued the lack of firm definition and procedures make the application of content analysis limited (Graneheim and Lundman, 2004; Hsieh and Shannon, 2005). For example, qualitative data can be interpreted in various ways and the understanding of the phenomenon can be dependent on the subjective inference (Graneheim and Lundman, 2004). In the next paragraph, the

concept of content analysis will be discussed to avoid any confusion or ambiguity for the purpose of understanding the data analysis procedure used in this study.

3.7.2 Different Approaches to Content Analysis

As previously stated, the common feature of quantitative and qualitative content analysis is that both approaches use a consistent set of codes to classify text data which contain similar meanings or concepts. The biggest differences between quantitative and qualitative content analysis are the coding procedure and the use of counting (Morgan, 1993). While generating codes in qualitative content analysis the researcher applies a more inductive way. The data were used as a source of their codes. When applying codes, the qualitative analysis is unlikely to use search algorithms or a pre-existing coding scheme which apply code automatically rather than relying on carefully reading original data and subjective coding. How to use counting is more important as a difference between qualitative and quantitative content analysis. In quantitative content analysis, the count of codes presents only a numeric summary of the data and further analytic steps are usually not taken forward, whereas, in qualitative content analysis, counting codes is regarded as just an initial step of interpreting the data and understanding the new contexts revealed by a coding and counting process. In qualitative content analysis, counting codes is a guide to direct the researcher to further interpretation of the data, and for the quantitative content analysis counting codes is usually treated as all that is needed to be known about the data. The following table shows the difference between qualitative and quantitative approaches in content analysis (Table 3-1) (Burla, Knierim, Barth, Liewald, Duetz and Abel, 2008).

Table 3-1: Quantitative and Qualitative Approaches in Content Analysis

1. Quantitative Content Analysis	Qualitative Content Analysis
<ul style="list-style-type: none"> ● Systematic and quantitative description of text data ● Testing hypothesis by statistical inference ● Focusing on the manifest contents ● Mainly deductive category application 	<ul style="list-style-type: none"> ● Systematic and rule-guided classification and description of text material ● Qualitative and quantitative presentation for results ● Focusing on manifest and latent contents ● Inductive category application

As mentioned before, there is no clear guide or universal rule to match a qualitative data analysis technique to a particular type of data or research goal. Thus, how to select an appropriate analytic technique and how to address the choice of them are key issues when analysing qualitative data. Morgan (1993) argued that qualitative content analysis is appropriate when the available data and the research purpose match the advantage of content analysis, which are describing and interpreting the context of the data (Morgan,

1993). For example, a study comparing the views or perspectives of two different samples is well matched to the strength of qualitative content analysis in terms of presenting the explicit answer to the question about what the differences are and also why the differences exist. Thus, in this study qualitative content analysis was applied.

3.7.3 Process of Qualitative Content Analysis

The lack of literature on meaning, concept, procedure and interpretation of qualitative content analysis has been addressed as a key issue (Graneheim and Lundman, 2004; Hsieh and Shannon, 2005; Elo and Kyngas, 2008). Hsieh and Shannon (2005) described 11 steps for conventional content analysis:

1. Reading all data repeatedly to obtain the sense of whole.
2. Highlight the exact word from the data that capture key thoughts or concepts.
3. Making notes of initial impressions or thoughts of the text.
4. Labels that are reflective more than one key thought will emerge.
5. Developing initial coding scheme from the labels emerged.
6. Code should be sorted into categories.
7. Grouping categories into meaningful clusters.
8. Organising subcategories into a bigger category.
9. Developing the definition of these categories, subcategories and codes.
10. Identifying the relationship between categories and subcategories if needed.
11. Addressing the relevant theory or other research finding if it is appropriate.

Although there are several approaches to qualitative content analysis, some of them take similar steps and share similar concepts. Elo and Kyngas described the process of qualitative content analysis with two different approaches; inductive and deductive. They

divided the process into three phases; preparation, organising and reporting. The initial step for the preparation phase is identifying the unit of analysis. The unit of analysis can be decided based on the purpose of the research and the source of data. Deciding on the depth of analysis is also important when identifying the unit of analysis, such as manifest or latent. In this phase, researchers are required to be familiar with the data and need to make sense of the data. Without this, data cannot be interpreted and no insights or theory will emerge. The next step for inductive content analysis is open coding, creating categories and abstractions, taking similar steps as conventional content analysis. Open coding is making notes and headings while you are reading the original data and creating categories with these headings and notes. During the process of creating categories, it has to be noted that creating categories is not simply bringing similar or related notes or headings together. They have to be classified as belonging to the particular category. Decisions have to be made, as well as some degree of interpretation, to which the unit of coding is then put in to the same category. After creating categories and grouping them in the bigger category, a general description of the research topic should be developed, and this process is called abstraction. Deductive content analysis shares the same concept as directed content analysis in the purpose of the data analysis and using the predetermined coding scheme developed from the previous literature or existing theory.

3.8 Questionnaires

Self-administrated questionnaires were applied in order to investigate the awareness of government policies related to nursing workforce planning, with particular focus on recently qualified nurses, and to investigate the impact of these policies at the local level with hospital based registered nurses. The questionnaires were used to supplement the data of the qualitative approach and also to gain a general view of the nursing practice environment in each country.

3.8.1 Justification for Using POWCS and PES-NWI

To investigate the impact of government policies on the ward level among registered nurses, the Perception of Workplace Change Schedule (POWCS) was chosen for the following reasons:

- The POWCS was the only tool found in the literature search that measures workplace change over the last 12 months.

- The POWCS has acceptable reliability and validity.
- The POWCS has been used in international study.

To investigate the nurse practice environment in Scotland and Japan, Practice Environment Scale-Nursing Work Index (PES-NWI) was chosen for the following reasons:

- The PES-NWI has been used in many studies.
- The PES-NWI has acceptable reliability and validity.
- The PES NWI has been used in the studies conducted in the UK and Japan.
- The PES-NWI in Japanese was available.

Therefore, the use of the POWCS and PES-NWI could be justified.

3.8.2 Validity and Reliability of POWCS and PES-NWI

Development of POWCS

The POWCS was developed and published by Nolan, Grant, Brown and Nolan during 1990s (Nolan, Grant, Brown and Nolan, 1998). Their purpose for developing the POWCS was to capture the perceived impact of NHS changes to understand the context where nurses work with specific factors that affect nurses' job satisfaction and morale. An initial survey with 1,760 nurses, midwives, health visitors and nursing students (response rate 53%) was conducted to capture their views towards their work conditions and government initiatives, such as views on professional accountability, perceptions of nursing role, views on other health professions and their work environment. Additionally, they aimed to provide a benchmark on the progress of changes by the government initiatives. After preliminary statistical analysis and content analysis of the first questionnaire, followed by a relevant literature review, a second survey was conducted with 1,640 nurses, midwives and health visitors (response rate 41%) to examine if the POWCS could be applied to other study contexts. POWCS is composed of 15 items that measure the personal work environment, the caring environment and the resources that these environments provide.

As identified by factor analysis, the POWCS has three subscales; pressure, strength and concerns, and it indicated that they are conceptually meaningful and statistically robust, and have good internal consistency (Cronbach α , 0.90). The four items in 'Pressure' reflect the aspect of the work environment, which may show the negative impact on RNs' wellbeing, such as job satisfaction and morale. 'Strength' has 7 items that measure the aspects that enhance the feeling of a positive work environment when they increase. 'Concerns' has 7 items that measure the aspect that enhance the feeling of a negative work environment when they decrease. Between 'Strength' and 'Concerns', 3 items overlap 'satisfaction with working conditions', 'feeling of being a valued employee' and 'the morale of colleagues'.

There was no Japanese version of the POWCS as it was initially developed to capture UK nursing. However, the POWCS was adapted and applied in an international study to measure the work place change in different nursing contexts (Schofield, Tolson, Arthur, Davies and Nolan, 2005). Schofield et al. modified two items of the original POWCS to take account of diverse study contexts and respondents. 'My confidence in the future of the NHS has' was modified to 'the resources I have to provide care' to make sense for the nurses who work in other countries. 'The amount of administrative work I have to do' was combined to 'the amount of time I have for direct patient care', which was already in the original POWCS, to make it relevant to all respondents. Additional questions, 'staffing level' and 'the amount of time I have to talk to patients', were added for clarification of work setting and the period of time working with patients. Thus, there were 16 items and 3 subscales in the modified POWCS. For the purpose of this study, the researcher decided to adapt the revised POWCS by Schofield et al. as the tool had been used in diverse study context (Schofield et al., 2005). The original POWCS was translated into Japanese for the purpose of this study. To ensure the quality of translation, the initial Japanese version of POWCS was back-translated (4.5.1).

Development of PES-NWI

Perceived Environment Scale-Nursing Work Index (PES-NWI) (Lake, 2002) was developed to measure the hospital nursing practice environment, based on the Nursing Work Index (Kramer and Hafner, 1989) that was originally developed to capture the organisational characteristic of magnet hospitals. The original NWI included 65 items and contained all factors related to staff nurse job satisfaction and quality of nursing care. Later on, the NWI was modified and used to measure organisational attributes of hospitals

(NWI-R) (Aiken and Patrician, 2000). Lake (2002) decided to use the source and content of NWI from these studies (Kramer and Hafner, 1989; Aiken and Patrician, 2000) to develop a universal measurement of nurse practice environment. Survey data from two samples of hospital staff nurses (Kramer and Hafner, 1989; Aiken et al., 2001) were used for data analysis. The first data were from the study by Kramer and Hafner conducted in 1985-1986. The sample was from a 25% random sample of nurses ($n=2,299$) (response rate 98%) from 16 magnet hospitals and 8 non-magnet hospitals in the USA. A typical respondent from a magnet hospital worked at a 200-300 bed urban, non-profit hospital whereas a typical respondent from a non-magnet hospital worked at a 700 bed or more, in a county or Veteran Affairs hospital. The second data were from the study by Aiken et al. (2001) with a 50% random sample of registered nurses ($n=41,860$) (response rate 52%) licensed in Pennsylvania. A subset of staff nurses ($n=11,636$) in 210 hospitals in Pennsylvania was used.

The PES-NWI development process involved five stages. Firstly, the 65 items from original NWI were reviewed and 48 items that measured the nursing practice environment were selected. Thus, items like 'home care programmes' and 'a satisfactoral salary' were excluded. Secondly, factor analysis was conducted to identify the subscale. Five subscales were identified and 31 items with high item-to-subscale correlation (salient loading) were retained. In the third stage, the reliability of PES was examined at individual and hospital level. Individual-level consistency for each subscale ranged using Cronbach's alpha from 0.71-0.84 (Lake, 2002). The hospital-level consistency was measured by inter-item correlations and intra-class correlation, which should exceed 0.6 to justify aggregation. They are quite robust with average inter-item correlation of 0.64-0.91 and intra-class correlation of 0.88-0.97 (Lake, 2002). At the fourth stage, the construct validity was examined by comparing the scores of nurses from magnet hospitals and non-magnet hospitals as it was expected that the score of nurses in magnet hospitals would have a significantly higher score compared to the one in non-magnet hospitals. The result supported the validity of subscales and items because the statistic showed the PES-NWI scores among non-magnet nurses were significantly less than magnet nurses ($p<0.001$) (Lake, 2002). Finally the generalisability of PES-NWI was assessed by an oblique multiple-group principle-components cluster analysis and the evidence supported the exploratory structure.

As identified by factor analysis, the PES-NWI has five subscales (Lake, 2002): Nurse Participation in Hospital Affairs; Nursing Foundations for Quality of Care; Nurse Manager

Ability; Leadership and Support of Nurses; Staffing and Resource Adequacy; and Collegial Nurse-Physician Relations. 'Nurse Participation in Hospital Affairs' has nine items and they measure the participatory role and the value of nurses in the hospital context. 'Nursing Foundations for Quality of Care' has 20 items and they reflect the nursing foundations for high standards of patient care such as nursing philosophy and nurses' clinical competency. 'Nurse Manager Ability, Leadership and Support of Nurses' has five items and they reflect the critical role of the nurse managers. 'Staffing and Resource Adequacy' has four items and they describe having adequate staff and recourses to support nurses in providing patient care. 'Collegial Nurse-Physician Relations' has three items and they describe the positive working relationship with physicians and nurses.

The PES-NWI asks nurses to rate each item from 1-4 (strongly disagree-strongly agree) to indicate their level of agreement to the statements related to their .current job. The subscale score (the average of the subscale items responses) for each subscale or composite score (mean of the subscale score) can be used to assess the hospital nursing practice environment (Lake and Friese, 2006). The potential score ranged from 1-4 and the higher score represents more agreement. Values on the average score for each subscale above 2.5 were considered as 'favourable' and the number of 'favourable' subscales indicated the three classifications of nursing practice environment: 'favourable' (4-5), 'mixed' (2-3), and 'unfavourable (0-1).

The PES-NWI and NWI-R, both originated from the NWI, were used in various international studies including Japan (Choi, Bakken, Larson, Du and Stone, 2004; Kanai-Pak, 2007; Aiken et al., 2008; Kanai-Pak et al., 2008; Aiken et al., 2011; Warshawsky and Havens, 2011). The NWI-R was translated by the Japanese researcher and then back-translated for the previous study (Izugami, 2007). The content validity of the Japanese version of NWI-R was assessed by the Japanese nursing researchers who are familiar with the work environment in the USA (Izugami, 2007). The Cronbach's alpha for each subscale ranged from 0.64-0.74 (Kanai-Pak, 2007).

The statistical analysis process for the questionnaire data is discussed in section 4.4.10

3.9 Ethical Issues

Ethical consideration of research in nursing should be included in the study design, and human rights of participants should be always guaranteed and protected (Polit and Beck,

2004). Conducting research ethically includes the whole process of research from identifying the topic to publishing the study (Burns and Grove, 2005). During the whole process of the study, human rights should be always protected and an ethical conduct of research should be exercised (Polit and Beck 2004).

Beauchamp and Childress (2001) state that a set of ethical principles should have the purpose of analysing the framework of evaluating rules underlined in the common morality and should also provide professionals with the function of considering ethical issues emerging from various situations (Beauchamp and Childress, 2001). Four basic ethical principles have been proposed: 'Beneficence', 'Non-maleficence', 'Justice', and 'Autonomy' and are discussed in the following sections.

3.9.1 Respect for Autonomy

Autonomy is described as the capacity for making decisions such as accepting, identifying and refusing without interference by others or from self-limitations, such as lack of adequate understanding (Beauchamp and Childress, 2001). The participants' autonomy should be respected by researchers. This is the obligation on health professionals and researchers so that they can report the data gained from participants (Beauchamp and Childress, 2001). Researchers thus should inform participants about a proposed study and gain their informed consent. In order to gain valid informed consent, it is crucial that researchers allow potential participants to make an autonomous decision whether they take part in the study or not.

In this study, a written consent form was gained from the all participants in order to respect their autonomy (4.4.3 and 4.5.4).

3.9.2 Non-maleficence

The principle of 'non-maleficence' is described as the obligation not to impose harm on others. Generally, avoiding harm and doing no harm to others are more rigorous and have priority over doing good to others (Beauchamp and Childress, 2001). However, because of the similar meaning of beneficence and non-maleficence, they are often described and discussed together. In terms of conducting research, it is essential to consider potential risks and benefits emerging from the study. Burns and Grove (2005) state that researchers should the balance benefits and risks of the study and consider the outcome of the study

(Burns and Grove 2005). It is easy to predict physical benefit, but it is difficult to predict psychological, economical and social outcomes. Thus, researchers should be particularly aware of potential risks provoked by the latter outcomes.

In this study, the researcher considered that this research would not bring any direct harm physically and/or psychologically to the participants. However, the researcher considered the pressure participants might perceive from the recruiting process and the time spent participating in this study (4.4.3 and 4.5.4). Additionally, the researcher was aware that reflecting on work issues might cause RNs to reflect later on nursing.

3.9.3 Beneficence

The principle of ‘beneficence’ is defined as a moral obligation act to bring benefit to others and to prevent and remove harm (Polit and Beck, 2004). Additionally, researchers are required not only to treat participants autonomously and avoid harm, but also to contribute to someone’s welfare (Beauchamp and Childress, 2001). Researchers need to minimise all kinds of harm and discomfort including physical, psychological, social and economical harms emerging from participation in the study. Researchers are obligated to present the benefits to participants, to prevent and minimise harm from the study and balance benefits and potential risks (Beauchamp and Childress, 2001; Polit and Beck, 2004).

In this study, participants did not gain direct benefit from taking part in this study and the fact participants were not gaining any direct benefit was made known to all potential participants (4.4.3 and 4.5.4).

3.9.4 Justice

‘Justice’ means equal shares for all, according to Aristotle (Beauchamp and Childress, 2001). It is also defined as “fair, equitable, and appropriate treatment in light what is due or owed to person” (Beauchamp and Childress 2001, p226). In terms of justice in research, participants should have an equal and fair opportunity to be provided before, during and after the study. Research subjects should be selected not because of their availability, compromised position, and manipulability, but because of their direct relationship to the study. Furthermore, justice should also guarantee the right of the participants’ privacy (Polit and Beck, 2004). All research including human subjects should ensure that their research is not intrusive to any participant and that their privacy is also guaranteed

throughout the study. Thus, any data from participants should be kept strictly confidential. An anonymous and confidential procedure should satisfy this obligation.

In this study, all collected data from the questionnaire were held securely on a pass-worded computer (4.4.3 and 4.5.4)

3.10 Establishing Study Rigor

Quantitative and qualitative research approaches have different criteria to assess the quality of study (Polit and Beck, 2004). For quantitative research, the most critical criteria are reliability and validity. For the qualitative research, to enhance the trustworthiness of the study's data, four dimensions are usually used to assess the quality of qualitative research (Lincoln and Guba 1985). Reliability indicate "the consistency if measures obtained in the use of a particular instrument" (Burns and Grove, 2005) and validity determines "the extent to which the instrument reflects the abstract construct being examined" (Burns and Grove, 2005). As reliability and validity of the data collection tools were discussed in the previous section (3.8.2), the trustworthiness of the qualitative study and the study rigor in cross-cultural study are discussed in the following sections.

As mentioned previously, to establish the trustworthiness of the qualitative data, there are four criteria: credibility, dependability, conformability and transferability (Lincoln and Guba, 1985). These criteria assess not only the quality of qualitative data, but also evaluations of interpretations and conclusions (Polit and Beck, 2004).

Credibility

Credibility refers to what extent the data and interpreting them reflect the truth (Polit and Beck, 2004). Lincoln and Guba (1985) suggested two aspects of credibility; conducting the research in a way to increase the believability of the findings, and to demonstrate credibility. There are some techniques to enhance and demonstrate the credibility of qualitative research.

The most important technique is to engage with the research for an extended period of time. It is important to have sufficient time to collect data in order to gain in-depth understanding of the study subjects (Polit and Beck, 2004).

The other technique is triangulation (Polit and Beck, 2004). As discussed before briefly (3.3), triangulation is the application of multiple referents in order to have comprehensive understanding and conceptualisation of the phenomenon. Within triangulation, there are four types: 1) data triangulation; 2) investigator triangulation; 3) theory triangulation; and 4) methodological triangulation (3.3). Three of these types were applied in this study. Data triangulation refers to the use of multiple data sources, such as collecting the same data at different timings, collecting data in multi-sites and collecting data from different groups of individuals. In this study, data were collected from different wards from different hospitals. Secondly, investigator triangulation, which includes two or more investigators during the data analysis and interpretation of the data sets, was applied. The researcher had one supervisor in Glasgow and a mentor in Kobe, Japan, and they were involved in the research process to provide supervision, in particular by the supervisor in Glasgow, and to give advice during the data collecting and analysis period, and have discussions about data analysis and presentation, in particular with the supervisor in Glasgow. Finally, methodological triangulation (3.3) was applied. The data were collected from multiple data sources such as interviews and questionnaires (POWCS and PES-NWI).

The other technique is peer debriefing that requires the researcher to have sessions with peers regarding the various aspects of inquiry (Polit and Beck, 2004). During peer debriefing, the researcher presents the written or oral summaries of data such as categories and themes emerging and interpretation of the data. In this study, the researcher had constant discussions with her colleagues in the department who were research assistants, or other PhD candidates, to discuss the research inquiries. In particular, the researcher had some discussion sessions with her colleagues about the themes emerging from the interview data (4.4.8). Member checking is also one other way to enhance the credibility of qualitative data. Member checking involves participants to review and comment on the data summaries that are gathered such as interview transcripts. In this study, the technique was not applied due to the limited time. Searching for disconfirming evidence can also enhance the credibility of the data. The conflicting views can strengthen a comprehensive understanding of the study object or phenomenon (Polit and Beck, 2004). During the recruitment process, the researcher made several decisions to recruit potential participants with different views and from different groups (4.4.5 and 4.5.6).

Dependability

Dependability has a similar concept to the stability and equivalence of reliability assessment in quantitative studies. It refers the stability of the data over time and conditions (Polit and Beck, 2004). In order to assess the dependability of qualitative data, stepwise replication and inquiry audit can be applied. Stepwise replication is where two independent individuals or a group from the same research group deal with data and compare regularly during the data analysis until agreement is reached (Polit and Beck, 2004). Inquiry audit involves external review of the data and relevant research documents. This approach can be also used to establish the conformability of the qualitative data.

In this study, the researcher was the only person who was involved in interviews Scotland and Japan, and who conducted the data analysis, which allowed the collected data to be stable. During the data collection and data analysis, external review of collected data and the report from the data analysis were conducted with the supervisor, the mentor in Japan, and the nurse researchers in the same office as the researcher. In that way the researcher was able to strengthen the rigor of the data analysis and the quality of data.

Confirmability

Confirmability refers to the potential compatibility where the data's accuracy, relevance or meaning can be agreed on between two or more people (Polit and Beck, 2004).

In this study, the researcher documented the process of data analysis and various documents, including the interview transcript and data analysis records which were provided to the supervisor and the mentor.

Transferability

Transferability can be rephrased by generalizability of data, which means to what extent the findings can be applicable to other contexts of the study settings. It was suggested that the researcher needed to report the sufficient descriptions about the data and study so that the others can assess the applicability of the findings to their own context.

In this study, the study design including sampling, study settings, data collection methods, data analysis and translation process were described (4.3-4.10). Thus, the transferability of this study can be judged by these descriptions about this research design.

Rigor in Cross-cultural Research

Im et al. (2004) suggested that study rigor in cross-cultural research cannot be established enough through the criteria described above because cross-cultural study sometimes deals with incommensurable concepts, phenomena, various issues related to culture and practical issues conducted in different research environments. Five criteria for the rigor in cross-cultural research are suggested: cultural relevance, contextuality, appropriateness, mutual respect and flexibility (Im et al., 2004). Cultural relevance asks researchers whether the research question can serve a specific cultural group's issues and interests in improving their lives. Contextuality refers to the contextual understanding, which requires sensitivity to the structural condition of the study settings during the interpreting of data. Appropriateness refers to whether the researchers applied appropriate communication styles, conceptualisations and translation. The importance of understanding preferred communication styles is emphasised. Mutual respect refers to having empathy and understanding of participants' views, beliefs and values. It is suggested that cross-cultural study also needs to be evaluated for flexibility in the language used and the time.

In this study, the study rigor in cross-cultural was established with the following reasons:

- Cultural Relevance: the research questions were to identify the similarities and differences of government policies and their impact at the ward level between Scotland and Japan in relation to RQNs, as justified before (3.4).
- Contextuality: the researcher had a good understanding of the context in each study setting as the researcher was originally from Japan and had experience of working in the study setting in Japan. Additionally, this researcher spent more than three years in Scotland and had experience of conducting a Master's research dissertation in those settings.
- Appropriateness: the researcher is bilingual, English and Japanese. Interviews were conducted in participants' language. Back-translation was applied where it was necessary.
- Mutual respect: the researcher respected the participants' views, beliefs and values during the research process.

- Flexibility: the researcher is bilingual, English and Japanese. Interviews and questionnaires were conducted in participants' language and the interviews were held at the participants' convenience.

Chapter 4: Methods and Material

In this chapter, the details of the steps taken to conduct this study are outlined and the study design, sample, site, ethical considerations, data collection tools, data collection process and data analysis are described.

4.1 Study Aims

The aim of this study was to identify similarities and differences between Scotland and Japan regarding the impact of government policies related to RQNs.

4.2 Research Questions

1. What government-driven policy exists to maintain the recently qualified nursing workforce in Scotland and Japan?
2. To what extent are registered nurses in clinical practice aware of these policies?
3. What are the responses of clinical practice to these workforce policies?
4. Do nurse managers and RQNs have issues and/or concerns related to these workforce policies?
5. Can an understanding of questions 1-4 suggest how policies related to RQNs could be better developed and implemented?

4.3 Study Design

Case study and a mixed methods research approach were applied to this study. This study was composed of two single case studies and employed both qualitative and quantitative methods to identify the similarities and differences between Scotland and Japan. Numbers in Table 4-1 represent the projected sample size range. Part 1 was in Scotland and Part 2 was in Japan. Each part was divided into two phases. Prior to this study, the researcher had informal interviews with academics from Higher Education Institutions in order to gain background for this study and a wider understanding of the nursing issues in Scotland and Japan.

Phase 1 was interviews with snowballing with a purposive sample of NHS staff including managers and RQNs in Scotland, and managers and RQNs in Japan. Phase 2 was a questionnaire with registered nurses. Interview data were collected by face-to-face, audio-recorded interviews using a semi-structured interview schedule with a purposive sample of RQNs and nurse managers. Semi-structured interviews were undertaken to gain the perception, opinions and ideas about government policy and implementation among nurse managers regarding workforce planning and recently qualified registered nurses. In addition a questionnaire was distributed to examine the impact of 'Flying Start' (FS) and 'Early Clinical Career Fellowships' (ECCFs) on the nursing workforce at local level with convenience sample of hospital based registered nurses in Scotland and in Japan a questionnaire was distributed to examine the impact of recent attempts and projects related to nursing workforce at local level with convenience sample of hospital based registered nurses. Content analysis was used for qualitative data analysis.

Table 4-1 Study Design

		Part 1: Scotland	Part 2: Japan
Phase 1	Interviews (n=40-60)	Nurse Manager (n=5) Ward Managers (n=5-10) RQNs (n=10-15)	Nurse Managers (n=5) Ward Managers (n=5-10) RQNs (n=10-15)
Phase 2	Questionnaires (n=400)	Registered Nurses in ICU/CCU/HDU (n=200)	Registered Nurses in ICU/CCU/HDU (n=200)
Data Collection Period		07/2009-03/2010	04/2010-09/2010

From this point, for the purpose of a clear understanding of this study, Part 1: Scotland and Part 2: Japan, are described and presented separately.

4.4 Part 1: Scotland

4.4.1 Study Site and Access

This study was conducted in seven adult ICUs/HDUs/CCUs in four university teaching hospitals listed within NHS Greater Glasgow and Clyde (NHSGGC). NHSGGC is the largest health board in Scotland delivering health care to 1.2 million people in 25 major hospitals, 10 specialist units and 60 health centre and clinics with 44,000 staff including 17,290 nursing and midwifery staff. (<http://www.nhs.gov.uk/content/>)

In order to access potential participants from the four study sites, the following steps were taken. Firstly, the Director of Nursing at the NHSGGC was approached who granted access approval to the target nurses in the proposed study. Secondly, relevant Hospital Directors granted access to hospital wards prior to the process of gaining Ethics and Research and Development (R&D) approval.

4.4.2 Ethics Approval and Research and Development (R&D) Approval

The Ethics Committee, Faculty of Medicine, University of Glasgow, granted research ethics approval for informal interviews. Phase 1 and 2 were approved by the West of Scotland Research Ethics Committee. The detailed process of gaining ethics approval and R&D management approval from each committee follows.

Phase 1 and 2: NHS Interviews and Questionnaire

For ethics approval, submission to the West of Scotland Research Ethics Service was made through the Integrated Research Application System (IRAS)³⁵ in June 2009. As required, the researcher attended the ethics committee. A few minor amendments to the study design description and minor changes to several documents were required such as the length of time for completing the questionnaire. Formal ethics approval was granted in July 2009 (Appendix V) with R&D Management Approval granted by Greater Glasgow & Clyde Health Board (Appendix VI). During the period of recruiting, the researcher made a change in the recruiting strategies in order to publicize the study at staff meetings. Ethics approval was sought again and granted for the change made in recruitment strategies in November 2009 (Appendix VII).

³⁵ <https://www.myresearchproject.org.uk/signin.aspx>

During the above process, additional documents were required in order to gain R&D Management approval for one particular hospital R&D office. Thus, submission to the NHS Research Scotland Coordinating Centre (NRSCC) was made through IRAS in September after receiving advice from the research coordinator. Management approval for three university teaching hospitals was granted in September 2009 and for the one other university hospital in October 2009 (Appendix VIII).

4.4.3 Ethical Considerations

During the research process, it is crucial to consider the ethical issues emerging from the study as the human rights of the participants should be protected (Polit and Beck, 2004). The four principles of biomedical ethics were addressed as the framework for examining the ethical issues in this study (Beauchamp and Childress, 2001); that is respect for autonomy, none-maleficence, beneficence and justice (3.7). Ethical issues emerging from this study were taken into account during the process of completing ethics approval applications for the ethics committee, Faculty of Medicine, University of Glasgow and the West of Scotland Research Ethics Service.

Respect for Autonomy

‘Autonomy’ is the capacity to self-rule without any interference from others or limitation such as inadequate understanding (Beauchamp and Childress, 2001). The principle of ‘respect for autonomy’ plays the most important role in decision-making process among potential participants (3.9)

In Scotland, all potential participants were professional nurses employed in the NHS. Thus the potential participants were considered as autonomous persons with the capacity to make rational decisions.

Potential interview participants were given the interview recruitment package including Letter of Invitation (Appendix IX), Participant Information Sheet (PIS) (Appendix X), Consent Form (Appendix XI) and Interview Guide (Appendix XII and Appendix XIII) via post or email. All potential participants had at least 24 hours to consider the information before they decided to take part or not in the interview. The consent form was signed and collected at the beginning of the interview. A copy of the consent form was given to the participants at the completion of the interview for reference. The interview was digitally

audio recorded with permission. The researcher explained again the purpose of recording the interview before the participants signed the consent form and that a decision to withdraw at any time from the study would not affect their employment.

Regarding questionnaire participants, the questionnaire recruitment package including Letter of Invitation (Appendix XIV), Participant Information Sheet (PIS) (Appendix XV), and Questionnaire (Appendix XVI) were distributed to the potential participants by either the researcher or the link nurse or ward managers. The return of the questionnaire was taken as willingness to be involved in the study and no specific consent form was requested from potential participants as completion of the questionnaire was taken as consent. Potential participants were asked to complete the questionnaire as soon as possible and return it to the researcher within four weeks from the time the questionnaire was received. The questionnaire was returned directly to the researcher in a stamped addressed envelope.

Non-maleficence

The risk of harming others should be carefully considered during the conduct of a study, which includes not only physical harm but also psychological, economical and social harm, which might occur as a result of this study. In this study, the researcher considered that there was no physical and or other harm to the participants. However, the researcher was aware that potential participants might feel some degree of psychological and social pressure during the recruitment process and interview. In addition, the length of time for the interview and completing the questionnaire were also taken into consideration so that taking part in this study was not inconvenient for participants.

Beneficence

As previously mentioned, 'Beneficence' is often confused with 'Non-maleficence'. The principle of 'Beneficence' is to act to promote or do something beneficial for others and prevent and remove something harmful to others (Beauchamp and Childress, 2001). In this study, the researcher was aware that there was no direct benefit to the participants by participating to this study. However, potential future benefit was mentioned in the PIS as it was hoped that this study would allow us to understand the current situation of recently qualified critical care nurses and also to inform others of associated nursing workforce related issues.

Justice

In research, participants should have an equal and fair opportunity to be provided before, during, and after the study. Research subjects should be selected not because of their availability, compromised position, and manipulability, but because of their direct relationship to the study. Furthermore, justice should also guarantee the right of the participants' privacy (Beauchamp and Childress, 2001; Polit and Beck, 2004).

Confidentiality and anonymity are important to the principle of 'Non-maleficence' and 'Justice'. In this study all potential participants were nurses employed by the NHS. All participants were anonymised in this study. To maintain confidentiality, the researcher took the following steps.

Digitally audio recorded interview data were held in a secure computer at the University of Glasgow and consent forms were held in a secure filing cabinet. These data and documents were accessible only to the researcher except on several occasions when the researcher asked one of the secretaries working in the same department to transcribe interviews. She was asked to respect the confidentiality of the interview data. The interview data were converted to a Waveform Audio File Format so that the researcher could play the recorded data on the computer for the purpose of transcribing and data analysis. Each audio-recorded interview was given an identification number so that only the researcher was able to identify the participants. After completion of interview data transcription, the secretary was no longer able to refer to any of the interview data she transcribed. Typing of transcriptions was anonymised. The secretary transcribed 12 interviews (checked again by the researcher after transcription) while the researcher transcribed 15 interviews.

Returned questionnaires were also held in a secure filing cabinet. The questionnaire data were coded and again held in a secure computer at the University of Glasgow. These data and original questionnaires were only accessible to the researcher. The returned questionnaires were given an identification number for the purpose of data analysis and preserving confidentiality.

All collected data will be destroyed on the successful completion of study and in line with ethics approval.

4.4.4 Sample and Sample Size

Phase 1: NHS Interviews

The study sample for the semi-structured interviews was purposive and identified by snowballing. The samples, sample size and inclusion criteria were the following:

- 5 nurse managers from the NHS involved in 'FS' and/or 'ECCFs'.
- 10 ward managers/ charge nurses/ ward sisters in ITUs/HDUs/CCUs/ICUs at the study sites where RQNs who were involved in 'FS' or ECCFs' were working.
- 15 RQNs registered for 24 months or less who had been/were involved in 'FS' or 'ECCFs' and working in ITUs/HDUs/CCUs/ICUs at the study sites.

The sample size for interviews with NHS staff was decided based on the assumption of potential participants with wide range background who were involved in 'FS' and/or 'ECCFs' so that the researcher was able to gain rich and varied data.

The researcher decided to conduct this study with the critical care/high dependency nursing workforce for the following reasons: (1) the researcher had previous experience of working in critical care settings in Japan. (2) It was easy to identify the samples of critical care/ high dependency nursing workforce in both countries.

In this study, RQNs were defined as nurses registered for 24 months or less in order to include RNs involved in ECCFs (To be involved in ECCFs, you should have completed FS which usually takes 12months).

Phase 2: NHS Questionnaire

The sample for the questionnaire was purposive and obtained via convenience sampling to meet the inclusion criteria as follows:

- Registered nurses in ITUs/HDUs/ICUs/CCUs working with RQNs in one of the study sites.

The exclusion criteria were the following:

- Bank nurses
- Registered nurses on sick leave or maternity leave.

The sample size of this phase was set at 200 after consideration of potential nurse numbers, the timeframe and manageability of data given that this was a cross cultural two country study. However, a strategy of over sampling was used. The researcher decided to apply this strategy because the exact number of registered nurses who met the inclusion criteria for the questionnaire was not known and the questionnaire response rate with NHS staff was expected to be around 38 per cent according to a previous national survey with NHS staff in Scotland (NHS Scotland, 2008). A 38 per cent response rate of 200 would provide 76 responses, which was sufficient for statistical analysis on statistical advice.

4.4.5 Identification and Recruitment Process

The recruitment period for Part 1 was from 27/09/2009-10/11/2009.

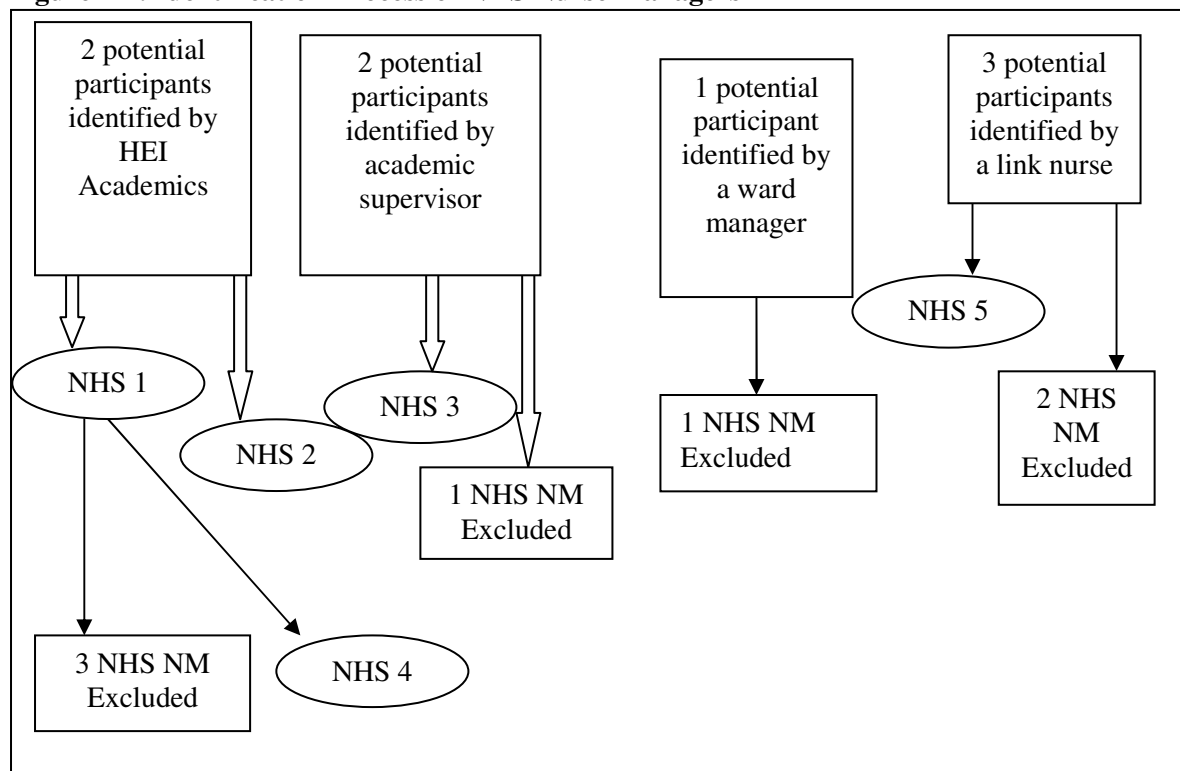
After gaining ethics approval and R&D management approval, the researcher identified and recruited potential participants for the study. Each step is described in the following paragraphs.

Phase 1: Identification and Recruitment Process for NHS Nurse Managers: Interviews

Two NHS nurse managers were identified by academics who the researcher had an informal interview with. Additionally, the academic supervisor identified two further potential participants, one of whom was excluded as she was on secondment and not available. One of these three participants identified a further four potential interviewees, of whom three were excluded after the discussion with the academic supervisor because of the similarity of their roles in the clinical area to others previously interviewed. Four other potential participants were identified, one by a ward manager and three by a link nurse during the recruitment process (Recruitment process and a link nurse are described in detail in the following paragraph), of whom three were excluded, again after discussion with the academic supervisor because they came from the same institution as other study participants. Within this identification process, 12 NHS nurse managers were identified, of whom five were interviewed and seven were excluded because their role was similar to the

other participants already interviewed. The following flowchart shows the identification process of nurse managers (Figure 4-1).

Figure 4-1: Identification Process of NHS Nurse Managers



After the identification of potential participants, initial contact was made via email or letter with a Study Protocol (Appendix XVII), Letter of Invitation (Appendix IX), PIS (Appendix X), Interview Guide (Appendix XII), and Consent Form (Appendix XI). A reminder letter and/or additional email were sent to potential participants who had not yet replied and one then agreed to be interviewed.

Phase 2: Identification and Recruitment Process: Wards

This study was conducted at seven ICUs/ITUs/HDUs/CCUs located in four different university teaching hospitals. Initially the researcher identified 6 university teaching hospitals after consideration of their location accessibility and personal contact. From these 6 hospitals listed in the NHSGGC website (<http://www.nhsggc.org.uk/content/>), 16 ICUs/ITUs/HDUs/CCUs were identified as potential study sites. These 16 wards were specifically seven ICUs/ITUs, seven HDUs and two CCUs. After ethics and R&D approval had been given to the researcher, initial contact was made with the ward managers/ senior charge nurses/ward sisters by letter (Appendix XVIII) and email to ask their permission to conduct a study in their clinical area. They were asked for their support in terms of

recruiting staff nurses. A study Protocol (Appendix XVII), Letter of Invitation (Appendix IX and Appendix XIV), Participant Information Sheet (PIS) (Appendix X and Appendix XV), Interview Guide (Appendix XII and Appendix XIII), Consent Form (Appendix XI), and Questionnaire (Appendix XVI) were attached/enclosed.

In particular, the researcher asked the ward manager for the following:

- Their permission to conduct the study in their ward.
- Their help to distribute the interview recruitment package to recently qualified nurses on the ward.
- Their help to distribute the questionnaire to all registered nurses on their ward.
- Their agreement to participate in the study by being interviewed.

At this point, eight managers from seven wards at potential study sites gave the researcher permission to conduct this study and agreed to support in terms of recruiting recently qualified nurses and distributing the questionnaire to all registered nurses working at the study sites. Six ward managers declined to give the researcher permission to conduct this study for the following reasons; the ward was too busy with many other tasks (n=4); the ward had other projects or audits ongoing (n=2).

In addition, three other ward managers agreed to take part in this study, but were excluded from the study because there were no recently qualified nurses on the ward at the point of recruitment. Therefore a total of seven wards in four study sites were involved in this study.

Phase1: Identification and Recruitment Process for Ward Managers Interviews

Identification and recruitment of ward managers for interview followed after identifying and recruiting the study wards. Ward managers on each study ward were identified by the researcher by making a phone call to each one and asking for their information and names. Interview recruitment packages including Letter of Invitation, PIS, Interview Guide, and Consent Form were given to the ward managers during the process of recruiting the study wards. Eight managers agreed informally to be interviewed. Nine ward managers declined to participate because of the reasons given before. Although eight ward managers were

identified, one was excluded as there were no recently qualified nurses involved in 'FS and/or ECCFs' on the ward. Thus seven ward managers were invited to the study and they all agreed to be interviewed.

Phase 1: Identification and Recruitment Process for Recently Qualified Nurse Interviews

Usually ward managers, and in one study site, a link nurse, identified the recently qualified nurses who met the study criteria (4.4.4). A total of 29 recently qualified nurses were identified from the seven participating study sites (4.4.1).

In addition, a NHS manager who the researcher had interviewed identified one recently qualified nurse who was based in the study health board. As she met the inclusion criteria for the interview, the researcher decided to include her as a potential participant and she was sent the recruitment package via email. A total of 30 recently qualified nurses who met the inclusion criteria were invited to the study in the following way.

1. All potential participants were identified by ward managers for interviews. The ward manager distributed the interview recruitment packages with a named envelope to potential participants individually.
2. The researcher put the potential participant's name on an envelope and distributed individually if the participants were on the ward when the researcher was visiting the ward.
3. Publicizing the study to the nurses was undertaken in the following ways; the researcher visited the ward several times with permission and gave a small talk to the nurses about this study and/or the researcher attended the staff meeting. If available, written notes were put in the communication book, which all nurses looked at during their shift. At one study site, a link nurse informed all nurses about this study by an email.
4. A reminder letter (Appendix XIX) was sent to all potential participants 1-2 weeks before the closing date for interview recruitment.
5. An email was sent to ward managers to ask their advice to maximise the response rate.

After these steps, a total of nine recently qualified nurses agreed to participate.

Phase 2: Identification and Recruitment Process for Registered Nurses Questionnaire

Ward managers or the link nurse from the seven participating study sites identified all registered nurses (n=318) on their wards for the purpose of the questionnaire distribution. The following steps were taken.

1. All potential participants were identified by the ward managers for questionnaires. The ward manager distributed the questionnaire recruitment packages with a named envelope to potential participants individually.
2. The researcher put the potential participant's name on an envelope and distributed individually if the participants were on the ward when the researcher was visiting the ward.
3. At one study site, a registered nurse working in a joint university-hospital appointment at the same Higher Education Institute as the researcher volunteered to be a link nurse to distribute the questionnaire individually to potential participants. So the questionnaire recruitment packages / interview recruitment packages were distributed individually by that link nurse.
4. Publicizing the study to the nurses was undertaken in the following ways; the researcher visited the ward several times with permission and gave a small talk to the nurses about this study and/or the researcher attended the staff meeting. If available, written notes were put in the communication book, which all nurses looked at during their shift. At one study site, a link nurse informed all nurses about this study by an email.
5. A reminder letter (Appendix XX) was sent to all potential participants 1-2 weeks before the due day for returning the questionnaire.
6. An email was sent to ward managers to ask their advice to maximise the response rate.

A systematic review of increasing responses to postal questionnaires reported by Edwards et al (2002) found that responses were more likely when the questionnaire was short,

personalized, used coloured ink, and had a stamped returned envelope (Edwards, Roberts, Clarke, DiGuseppi, Pratap, Wentz and Kwan, 2002). In addition, previous personal contact with potential participants was found to increase the likelihood of getting responses. In this study, this evidence was implemented. As can be seen in Table 4-2, the researcher prepared the questionnaire package and interview recruitment package with a stamped addressed free post envelope. Each questionnaire package and interview recruitment package was addressed personally except for one study site where they had a link nurse who distributed the questionnaire packages to each potential participant face to face during her shift, but it was not addressed personally in order to make the process of distribution easier. When the researcher was given the opportunity to distribute the recruitment package individually face to face, she did so. Initially, the researcher attempted to attend a staff meeting at each study site. However, there were few regular staff meetings. Therefore, the researcher took a different approach to publicize the study. The researcher visited six wards and gave a small talk about the study, but at one study site, the researcher did not have the opportunity to give a small talk. In addition, in some of the seven study sites the researcher was given permission by the ward manager to send out a reminder. Although the researcher made an amendment to the recruitment process and gained the approval for a poster, the poster was not used for maximising the response rate for the following reasons; by the time the researcher gained the approval, the return date of questionnaire and the recruitment period for the interview was passed and several ward managers and a link nurse suggested alternative approaches to the researcher to maximize response rate.

The Table 4-2 shows each step taken in order to gain the maximum response from all potentials participants.

Table 4-2: Steps to Maximize the Response Rate

	Study Site						
	A	B	C	D	E	F	G
Putting individual names on the recruitment packages (questionnaire and interview packages)	✓	✓	✓	✓	✓	*1	✓
Distribution of the recruitment package individually face to face by ward manager or link nurse	✓	*2	✓	*2	*2	✓	✓
Distributing the recruitment package individually face to face by the researcher	✓	*3	*3	✓	✓	✓	*3
Researcher giving a small talk about this study to nurses on the ward	✓	✓	✓	✓	✓	✓	*4
Attended staff meeting	No regular staff meeting	✓	No regular staff meeting	No regular staff meeting	No regular staff meeting	No regular staff meeting	No regular staff meeting
Writing notes in the communication book	No book	No book	✓	✓	No book	No book	No book
Researcher sends reminder letter before the return date of the questionnaire	✓	✓	*5	✓	✓	*6	✓
Researcher sends reminder letter before the due day for the interview	*7	No nurse	✓	✓	✓	*6	✓

*1: Link nurse declined to put names on envelopes

*2: Declined, recruitment packages were left in the staff room

*3: Declined, not given the opportunity to distribute them because the ward was too busy to do so.

*4: Ward Manager was on annual leave.

*5: Reminder email sent by a ward manager

*6: Reminder email sent by the link nurse

*7: No need to send because the potential participant agreed with the interview

4.4.6 Data Collection Tools

Interview Schedule

There were two different interview schedules; one for NHS nurse managers including ward managers (Appendix XII); and one for recently qualified nurses (Appendix XIII).

The interview schedule for NHS nurse managers including ward managers was composed of two parts. The first part consisted of six questions (Q1-Q6) that probed their perceptions, opinions, concerns and issues related to government policies regarding nursing workforce planning. The second part focused on about their perceptions and opinions about 'FS' and 'ECCFs'. Questions (Q7-Q8) were about their expectations and

perceptions of 'FS' and 'ECCFs'. The next two questions (Q9-Q10) aimed to probe the responses and changes due to these two programmes. The following question (Q11) was about their concerns and issues related to 'FS' and 'ECCFs' and their perceptions of key factors in achieving the goal of these initiatives (Q12). The last questions (Q13-Q14) explored more about the programme and asked for their comment on these matters.

The interview schedule for recently qualified nurses was composed of two parts. The first part probed their experiences of being a recently qualified nurse (Q1-Q5) while the second part was aimed at their experience of being involved in 'FS' and/or 'ECCFs' (Q6-Q15). The last questions were about their concerns or recommendations for other recent qualified nurses.

Construction of the Questionnaire

In this study, a specially designed questionnaire (Appendix XVI) was applied to examine the impact of government policies related to recently qualified nurses; 'FS' and 'ECCFs' on the nursing workforce at local level with critical care nurses and to provide a general view of the nursing practice environment in Scotland. The questionnaire included participant demographics and three further sections: in relation to change in their work place; in relation to experiences as a recently qualified nurse; and in relation to their working environment.

The first part of the questionnaire was about demographic data. Participants were asked to tick the most appropriate box for each question e.g. gender, work experience, length of registration and educational background. The questionnaire then filtered participants to a) those who had been registered for 24 months or less (recently qualified nurses) and b) those who had been registered more than 24 months. For those who had been registered for 24 months or less, they were asked to complete Sections 2 and 3. For those who have been registered for more than 24 months, they were asked to complete Sections 1 and 3.

In Section 1, perceptions of workplace change were measured by using the POWCS (Perception of Workplace Change Schedule) (3.8.1) (Nolan et al., 1998; Schofield et al., 2005). The original POWCS has 15 items in three sub-scales; Pressure, Concerns, and Strength. The researcher gained written approval from the original author and used the modified POWCS which was used in the previous international study with 16 items (Schofield et al., 2005) (see 3.8.1). The researcher gained permission to use this tool from

Nolan³⁶. Minor changes were made to further understanding; for example 'workplace change' became 'things have changed in relation to your work'. Participants were asked to tick the best reflective statement from five options; 'Decreased a lot', 'Decreased a little', 'Stayed about the same', 'Increased a little', 'Increased a lot'. At the end of Section 1, participants were asked how much they were aware of government policies related to their area of clinical practice in terms of health policy and nursing workforce planning. Finally, participants were asked about their involvement in the 'Early Clinical Career Fellowship' and 'FS' programmes or projects targeted at recently qualified nurses.

Section 2 was designed only for recently qualified nurses to complete. In this section, experiences of being recently qualified were explored. A part of this section was developed by the researcher based on the results taken from a report by the Japanese Nursing Association (JNA, 2005). The JNA asked a range of questions but for the purposes of this study only two questions were used: 'What kind of factors make it difficult for recently qualified nurses to familiarize themselves into clinical practice'; and 'What are the reasons for recently qualified nurses to signal their intention to leave their current job'. There were 27 different answers for these two questions. Therefore the researcher grouped these 27 answers into 12 different factors. These 12 factors included for example, 'lack of knowledge about essential nursing care' and 'negative feelings towards job and working environment'. The factors were then translated from Japanese into English and discussed with her supervisor regarding their equivalence. Additionally the content of Section 2, that is the translated English and original Japanese were compared by bilinguals. Back translation was carried out on the entire questionnaire [English to Japanese] and was deemed appropriate.

In Section 2, participants were asked to tick the most appropriate box for each factor. The options for the answers were 'A great deal', 'Very much', 'to some degree', 'a little', and 'Not at all'. There were also three open-ended questions. The first asked if there were any other factors that made it difficult for them to familiarise themselves into clinical practice. The second one asked them to identify the factors that made it easy for them to familiarize themselves into clinical practice. The last one asked them to describe the organisational support they had had since they started working. Participants were also asked how satisfied with 'FS', 'ECCFs', and their experience of being a recently qualified nurse.

³⁶ Personal Communication via e-mail

Section 3 was designed for all registered nurses to complete. In this section, their perceptions of the hospital nursing practice environment were measured with the PES-NWI (Practice Environment Scale-Nursing Working Index). The PES-NWI was adapted from the published paper for the purpose of this study (Lake, 2002). The original tool was developed in the USA. Because there were organizational, political and cultural differences between hospitals in the USA and UK, several changes were made in specific words for clearer understanding with British English under the advice of supervisor (e.g. 'administration' to 'hospital', 'A chief nursing officer' to 'Division's Nursing Lead', 'supervisors' to 'managers'.) In addition, several statements were rephrased to provide a clearer understanding of statement after discussion with the supervisor. For example, 'collaboration between nurses and physicians' was rephrased to 'We have collaboration between nurses and physicians' and 'Adequate support services allow me to spend time with my patients' rephrased to 'Our hospital believes that it is important for me to spend time with my patients'. Initially, the PES-NWI had 31 items to measure the hospital nursing practice environment in 5 subscales (Nurse Participation in Hospital Affairs, Nursing Foundations for Quality of Care; Nurse Manager Ability, Leadership, and Support of Nurses; Staffing and Resource Adequacy; Collegial Nurse-Physician Relations). However, one item, 'Use of nursing diagnosis', was omitted after the discussion with supervisor because it was concluded that this item does not measure the nursing practice environment in the UK and it was also omitted from another study (Aiken et al., 2008). Participants were asked to scale from 1-4 ('strongly agree', 'somewhat agree', 'somewhat disagree' and 'strongly disagree'), to express their level of agreement to the statements. At the end of this section, participants were asked their intention to leave their current job and nursing with five different options; 'Never', 'Occasionally in the last 12 months', 'Sometimes every month', 'Sometimes every week', 'Every day'.

4.4.7 Pre-testing of the Data Collection Instrument and Pilot Studies

Pilot Studies

A pilot study is defined as a smaller version of the proposed study (Burns and Grove, 2005) and it is often conducted not only to refine the methodology but also to develop every step of research process including intervention, data collection instruments, and sampling recruitment strategies. The purpose of conducting pilot studies varies.

- To test the feasibility of the proposed study including cost and time (Polit and Beck, 2004)
- To develop, refine and examine the data collection instruments (Burns and Grove, 2005)
- To develop, refine and examine the research interventions (Polit and Beck, 2004)
- To examine the several steps of the research process such as sampling methods, sample recruiting strategies and data analysis techniques, (Burns and Grove, 2005)
- To provide research experience of the study settings and study methods such as interviews and interventions (Burns and Grove, 2005)
- To identify potential problems with the study design (Polit and Beck, 2004).

Pilot Study and Pre-testing of the data Collection Instrument Objectives

After gaining ethics and R&D approval, pre-testing of the data collection instrument and a pilot study was conducted for Phase 1 and 2 with the following objectives:

- To give the researcher experience with the interview procedure and to improve the researcher's interview skills and overall performance,
- To test the quality of recording equipment,
- To examine the quality of recorded data for data analysis,
- To examine the wording of interview questions and the questionnaire in terms of participants' understanding,
- To examine the order of questions in terms of participants' understanding.

Pre-testing the Data Collection Instrument

After gaining ethics and R&D approval, pre-testing the data collection instrument was conducted with 16 MSc Health Care second year students. Their nursing backgrounds

varied so that the researcher was able to gain feedback from nurses with various and different perspectives. Either the interview schedule (Appendix XII and Appendix XIII) (n=8) or the questionnaire (Appendix XVI) (n=8) was distributed to the students. They were asked to give feedback about the contents.

Most of the feedback was positive and favourable. Both the interview guide and questionnaire were easy to understand and follow. One comment was made on the options for one of the questions in the questionnaire. Minor amendments were made. One optional answer, 'Heard of one of them, but not involved', was added to the original options.

Pilot Study for the Interviews

The pilot study for Phase 1 interviews was conducted with three nurse academics working at the University of Glasgow. One was a research assistant with recent clinical working experience in the ward and the other two were lecturers who were familiar with either 'ECCFs' and/or 'FS'. They were recruited directly by the researcher via email or face-to-face. The pilot interviews took place either in their office or in one of the quiet rooms in Nursing & Health Care. Interviews lasted 25 to 40 minutes. The first two interviews were recorded for the purpose of testing the quality of recording equipment and the last interview was not recorded because the researcher forgot to turn on the equipment during the interview. Participants were asked to feedback about the wording and order of the interview questions, and the overall performance of the researcher as an interviewer.

As a result the following findings emerged.

- The researcher was able to familiarise herself with the interview process, although at the first interview, she was aware of some degree of stress and anxiety. Good feedback was given to the researcher in terms of overall interview performance.
- The recording equipment worked well and the transference of recorded data into the personal computer was also successful.
- The quality of the transferred data was good enough for data analysis.
- Several suggestions were made for the wording of interview questions as some needed to be rephrased in order to make it easier for interviewees to answer. For

example, 'What do you think the key factor in making FS and/or ECCFs work?' was changed to more a specific question: 'What do you think the key factors are in achieving the goals of these programmes?'

- The order of interview questions flowed smoothly from one question to another question.

Overall Summary

A few minor amendments were made as a result of piloting. The researcher was able to establish interview skills and familiarise herself with the interview environment. All pilot study data were excluded from the main study data analysis.

4.4.8 Data Collection Process

Conduct of Interviews

Interview appointments were usually made via email, but occasionally face to face or through phone calls according to the preference of participants.

All interviews started after the researcher introduced herself and explained the study briefly. Participants were then asked to sign the consent form.

Interviews with NHS nurse managers and ward managers were mostly held in their office or in an available room at their hospital. However, one interview with a NHS nurse manager was held in a public space where other people were sitting. The interviewee chose this place because it was the most convenient and accessible place for her to spare time for the interview. This interview was very difficult to carry out for both the researcher and the interviewee due to the surrounding noise. At the end of the interview, the interviewee offered the researcher further contact if there was anything unclear or things to clarify. The interview time with NHS nurse managers and ward managers varied from 11 to 45 minutes.

Interviews with recently qualified nurses were held at three different places; available rooms at their hospital, an interview room at the University of Glasgow, and public places at the hospital. Even though one of the interviews was held in a public place, all the places

and rooms were quiet and private. The interview time with recently qualified nurses varied from 12 to 44 minutes.

In terms of digitally audio recording, all participants agreed to be recorded and none of them withdrew from the interview.

Most of the interviewees seemed to be relaxed and comfortable with the researcher. However, several NHS nurse managers and ward managers seemed busy. Thus the researcher felt a bit of pressure to make the interview flow smoothly.

Field Notes

Field notes were taken after the each interview in order to gain depth understanding of the interviews and to reflect for the following interviews. The researcher developed a template (Appendix XXI) for the field note that provide additional information such as length of interview, atmosphere during the interviews, idea emerged during the interviews, brief summary of the interview performance, personal questions, and key words during the interviews.

4.4.9 Data Analysis of Interview Data

Transcribing

The digital audio recorded interview data were transferred to a secure computer at the University of Glasgow. Verbatim transcribing was undertaken shortly after the interview by the researcher or a secretary as previously described. The researcher would go through the recorded interview once the initial transcription was completed by the secretary to ensure the transcription was accurate and a valid reflection on the whole content of the interview. Because the researcher is not a native English speaker, a research assistant in the same department, who had experience in transcribing interviews, reviewed some of the interview content where the researcher could not catch a word or could not understand the meaning. In this way, transcriptions were checked to ensure they were a valid reflection on the whole content of the interview.

Organizing data and constructing categories with Nvivo

Interview data were organized and analysed using the computer assisted qualitative data analysis software, Nvivo version 8. Interview data were analyzed separately by samples; NHS nurse managers, ward managers, and recently qualified nurses.

The following steps were applied to all interview data in order to create categories and carry out content analysis.

1. After transcribing interviews, all transcriptions were imported to Nvivo along with the original recorded interview. Field notes and recorded audio data were also imported to Nvivo so that the researcher could refer to other resources while working with Nvivo.
2. The first interview to be analysed was chosen based on the researcher's field notes that provided information on the interview. Bazeley (2007) suggests that the first interview to be analysed should be chosen deliberately and should be 'typical' in some way, or representative in some way of the group, or one that is particularly 'interesting.' Thus the researcher chose one that was particularly 'interesting'.
3. After choosing the first document to analyse, the transcription was read several times to gain the sense of whole. During this first reading, notes and comments were made using the 'annotating' function in Nvivo (Bazely, 2007).
4. For the second reading, the 'free nodes' function in Nvivo was used to identify the part of text that addressed specific topics. The interview guide was used as a framework to identify specific topics such as the perception of objectives and issues on 'FS' and 'ECCFs'. Additional 'free nodes' were made according to the interview questions, which were not specifically addressed in the interview guide but were asked during the interview.
5. After identifying 'free nodes', the researcher read each 'free node' several times and identified sentences or paragraphs related to each other. A reflective label of the contents was given to these units and these reflective labels were saved as 'tree nodes'.

6. After identifying the unit from the content of 'free node' and naming the unit into 'tree nodes', these 'tree nodes' were categorized into several groups and these groups were categorised with the new bigger labels that reflected the contents (sub categories).
7. After grouping them with the bigger labels, (sub-categories), they were sorted into bigger group (category) and themes extracted from these categories.

Extracting Themes and Organising them

After completing the initial data analysis of interview data, all emerged themes were discussed with her supervisor and the nurse researchers in the same department. After a couple of discussions some categories were re-organised and themes were re-named in order to reflect the interview data.

4.4.10 Data analysis of Questionnaire Data

On statistical advice, SPSS version 15 and Minitab version 16 were used for statistical data analysis. The data from questionnaires were coded and put in SPSS first as numeric data. All returned questionnaires were given an identification number on return. After being given an identification number, each question and each answer was given a code number so that the researcher could type them into SPSS. The following examples were treated as missing data.

- Participants ticked more than two boxes where they should have ticked only one.
- The participant ticked unclearly so that the researcher was not able to judge which answer was ticked.
- Instead of ticking the box, some sentence was written in the box.

Descriptive statistics, the chi-square test, and *t*-test (two-tailed) were used to profile the respondents and identify the trend of answers for the questionnaire.

For demographics, descriptive statistics and chi-square test were used to present the characteristics of the respondents.

In Section 1, questions 5-20, descriptive statistics and the chi square test (Goodness of Fit) were applied. Most data in Section 1 were nominal data. In order to conduct accurate calculation, answers were grouped; 'decreased a lot' and 'decreased a little' were grouped as 'decreased'; 'increased a little' and 'increased a lot' were grouped as 'increased' and agreed by the statistician.

Firstly, the chi-square (Goodness of Fit) test was applied to examine changes in the perception among Scottish RNs towards their workplace change. The value in 'decreased' and 'increased' was used to test if there were any significant differences in distribution between 'increased' and 'decreased'.

Secondly, for questions 21-23, 'a great deal' and 'very much' were grouped as 'very much', and 'to some degree' and 'a little' were grouped as 'some degree' on statistical advice. The chi-square test was applied to examine if the distribution of the answers differed between each answer ('very much', 'some degree', and 'not at all').

In Section 2, most data were nominal data. Grouping some of the categories together was used to overcome the statistical problem of small frequencies. For questions 26-37 (asking factors made RQNs' familiarisation into clinical practice difficult), 42, 46, and 48 (asking RQNs' experiences of being involved in ECCFs or FS), 'a great deal' and 'very much' were grouped as 'very much', and 'to some degree' and 'a little' were grouped as 'some degree'. For question 41 (asking their satisfaction with organisation's support), 'very satisfied' and 'moderately satisfied' were grouped as 'satisfied', and 'moderately dissatisfied' and 'very dissatisfied' were grouped as 'dissatisfied'. Finally, for questions 49 (asking overall RQNs' experience), 'very good' and 'good' were grouped as 'good', and 'bad' and 'very bad' were grouped as 'bad'. Descriptive statistics were conducted in this section and no statistical test was applied due to the small number of respondents for this section.

In Section 3, for questions 50-79, 'strongly agree' and 'somewhat agree' were grouped as 'agree'; 'strongly disagree' and 'somewhat disagree' were grouped as 'disagree'. For questions 50-79, the chi-square test was conducted to examine if there was any difference in the distribution between 'agree' and 'disagree' within Scotland.

Additionally, for questions 50-79 in Section 3, the average score for each subscale (Nurse Participation in Hospital Affairs, Nursing Foundations for Quality of Care; Nurse Manager

Ability, Leadership, and Support of Nurses; Staffing and Resource Adequacy; Collegial Nurse-Physician Relations) was calculated and the total average scores for questions 50-79 were calculated. For this calculation, grouping was not applied and raw data were used. The potential average score ranged from 1-4 and higher the score represents more agreement. Values on the average score for each subscale above 2.5 were considered as 'favourable' and the number of 'favourable' subscales indicated the three classifications of nursing practice environment, 'favourable' (4-5), 'mixed' (2-3), and 'unfavourable' (0-1). The sample with missing data for the each subscale and total average score were excluded from these calculations. Thus the total number for each subscale was different for each subscale. The researcher decided to exclude the sample with missing data from calculation because it was the simplest and most reasonable way on a statistical advice.

Comparison of the results from Sections 1-3 between Scotland and Japan was undertaken where it was relevant. The chi-square tests were applied to examine if the distribution of answers between Scotland and Japan were different. In Section 3, mean scores of subscales and total average scores of the adapted RES-NWI were compared by the two-tailed *t*-test.

'Multiple comparisons' were taken into the consideration when the researcher was interpreting the results. On statistical advice, a formal correction for multiple testing such as Bonferroni's correction was not applied in this study because it was difficult to know what level of correction to apply. The researcher was advised to avoid over-interpretation of associations or differences on the borderline significances by the statistician. The researcher therefore decided to report the results at the significance level of $p < 0.01$ rather than $p < 0.05$.

Part 2: Japan is described from this point.

4.5 Part 2: Japan

Part 2 proceeded in much the same way as Part 1 in Scotland. However, due to the distinctive differences between the two countries in terms of culture, health care delivery system, nursing education system, and the employment system (see 2.7.5), several amendments were made in the procedures. The following sections describe the process for Part 2 in Japan and differences between Scotland and Japan in terms of study process.

4.5.1 Translating Data Collection Instruments

All research documents were back translated except the PIS and the Letter of Invitation. The Letter of Invitation was combined with the PIS because the required contents of the Japanese PIS were slightly different from the Scottish PIS. In addition one of the Directors of Nursing required that several sentences be changed in the PIS to reflect Japan's culture; for example, the way in which things are explained is different, as is the way they address issues related to the research. Thus it is difficult to establish the equivalence of meaning and also create relevant documents that could apply in Japanese culture through back translation. However, to address ethical issues, the PIS was developed based on Japanese guidance for nursing research³⁷ and the PIS Scotland version. After developing the Japanese PIS, the contents were checked several times with a bilingual person to check the Japanese PIS contained the same contents as the Scottish PIS.

The Interview Guide (Appendix XXII and Appendix XXIII), Consent Form (Appendix XXIV), and Questionnaire (Appendix XXV) were back translated. The researcher translated original documents from English to Japanese and three bilinguals back translated from Japanese to English. These people were educated at university level and one of them had a Master's degree in translation. After translation, the supervisor and the researcher checked the content and meaning of these documents. In the questionnaire and the interview guide, there were several sentences that did not have the equivalent meaning to the original documents. Thus these sentences were back translated again with different bilinguals. After the second back translation, again the back-translated documents were checked with the supervisor and the researcher. Both agreed with the contents of back-translated documents so that a good translation was reached.

³⁷ www.nurse.or.jp/nursing/international/icn/definition/data/guiding.pdf

4.5.2 Study Site and Access

Phase 1 and 2: University Teaching Hospitals

Kobe is the capital city of Hyogo prefecture that is located in western Japan. Kobe has 1.5 million people and more than 100 private and public hospitals where 16,143 nursing staff are working including public health nurses and midwives (Personal phone calls to Hyogo Prefecture confirmed numbers). Initially the researcher identified all hospitals in Kobe listed in the Hyogo prefecture website and identified 13 university teaching hospitals in Kobe that were funded by local or national government or equivalent institute with a public purpose. Since the health care system is different from Scotland, it is difficult to identify the hospitals that had similar functions and organisational structures as NHS Scotland. Thus the researcher decided to identify the hospitals using the following criteria in order to maximise the similarity of each hospital's characteristics, functions and expected role in society:

- University teaching hospital
- Funded by local or national government, or by a public organisation, which has the purpose of contributing public benefit
- Having ICUs/ITUs/HDUs/CCUs
- Having more than 300 beds.

A total of five hospitals were identified as potential study sites. Initial contact was made with the five hospitals and two Nursing Directors agreed to participate. Therefore Part 2 was conducted at two university teaching hospitals in Kobe. These hospitals were categorised as large hospitals and play the main role in providing high quality medical care in Kobe.

In order to access potential participants, the following steps were taken. The researcher sent an official letter to the Director of Nursing at the study sites (Appendix XXVI). The letter requested the opportunity to discuss the study face to face and the process of gaining research approval at the each hospital. In August 2009, the researcher was given the opportunity to visit the study sites to discuss conducting this study. Informal agreement

was made with two hospitals. Additional documents including the study protocol (Appendix XVII), patient information sheet (PIS) (Appendix X and Appendix XV), interview guide (Appendix XII and Appendix XIII), questionnaire (Appendix XVI), which had been used in Scotland were requested by the hospitals in order to provide the researcher official research and ethics approval.

4.5.3 Ethics Approval and Management Approval

In Japan, there is no integrated system for gaining ethics approval for a study that includes patients and health care professions. Ethical approval needs to be granted by each study site. The Ministry of Health, Welfare and Labour and the Japanese Nursing Association have published guidelines for researchers and institutions to conduct ethical research with patients (JNA, 2004a; MHLW, 2004b). Thus this study followed these guidelines and ethical approval was gained from each study site (Appendix XXVII and Appendix XXVIII). In addition, the same processes as in Part 1 were undertaken where applicable in Part 2, Phase 1. However, recruitment packages to be distributed to the potential participants were amended. The Letter of Invitation was not used because it is common to combine the PIS and the Letter of Invitation in Japan.

Phase 1 University Teaching Hospitals

Although each study site hospital had their own Ethics Committee for research conducted in clinical practice, this study was exempted from the usual procedure of ethics approval because this study did not include any patients. The Director of Nursing at each hospital was delegated the decision making for granting research and ethics approval. Thus, the researcher submitted the Study Protocol in Japanese (Appendix XXIX), PIS (Appendix XXX, Appendix XXXI, and Appendix XXXII), Interview Guides (Appendix XXXIII and Appendix XXXIV: Interview Guide for RQNs (Part 2 Japan)), Consent Form (Appendix XXXV), and Questionnaire (Appendix XXXVI), to each Director of Nursing at each hospital in August 2009. Decisions were made between the Directors of Nursing and nursing managers at each hospital. A minor amendment was required in the PIS. The Director of Nursing from one hospital required the researcher to put a particular sentence in the PIS when the researcher was talking about potential participants' right to withdraw. 'You are allowed to refuse the recording of the interview' was added to the PIS. Due to the amendment of the PIS, an additional sentence was added to the consent form which was 'I permit the researcher to take notes during the interview and I permit the researcher to use

the anonymised notes for her/his papers, conference and any other means of presentation'. Due to the time schedule of this study, formal research approval was granted in May 2010 (Appendix XXVII and Appendix XXVIII).

4.5.4 Ethical Considerations

Consideration of ethical issues in Part 2 followed the same process as Part 1(4.4.3). Ethical issues emerging from Part 2 were taken into account during the process of gaining research approval from each study site as set out before.

Respect for Autonomy

In Part 2, all potential participants were registered nurses employed in the university teaching hospitals. Thus the potential participants were considered as autonomous persons with the capacity to make rational decisions.

Potential interview participants were given the recruitment package including, Participant Information Sheet (PIS) (Appendix XXX and Appendix XXXI), Consent Form (Appendix XXXV) and Interview Guide (Appendix XXXIII and Appendix XXXIV) via post or email. All potential participants had at least 24 hours to consider the information before they decided to take part or not in the interview. The consent form was signed and collected at the beginning of the interview. A copy of the consent form was given to the participants at the completion of the interview for reference. The interview was digitally audio recorded with their permission. The researcher explained again the purpose of recording the interview before the participants signed the consent form and that a decision to withdraw at any time from the study would not affect their employment. The potential participants were allowed to refuse the researcher to record the interview.

Regarding questionnaire participants, the recruitment package including Participant Information Sheet (PIS) (Appendix XXXII) and Questionnaire (Appendix XXXVI) were distributed to the potential participants. The return of the questionnaire was taken as willingness to be involved in the study and no specific consent form was requested from potential participants as completion of the questionnaire was taken as consent. Potential participants were asked to complete the questionnaire as soon as possible and put it into a designated box within four weeks from the time the questionnaire was received. The researcher collected completed questionnaires from the designated box regularly.

Non-maleficence

As before (4.4.3), the four principles were considered. Only where there was variation from Part 1, are these reported separately below.

Confidentiality and anonymity are important to the principle of 'Non-maleficence'. In this Part 2 study all potential participants were registered nurses who passed the national exam board. All participants were anonymised in this study. To maintain confidentiality, the researcher took the same steps as Part 1 in Scotland except for few different points.

Digitally audio recorded interview data were held in a secure computer at the researcher's private residence in Japan during the data collection and consent forms were held in a secure filing cabinet at her private residence. These data and documents were accessible only to the researcher. The interview data were saved in a Waveform Audio File Format so that the researcher could play the recorded data on the computer for the purpose of transcribing and data analysis. Each audio-recorded interview was given an identification number so that only the researcher was able to refer the participants.

The designated box for the completed questionnaire was either in the staff room or at the nursing station on the ward. The designated box was emptied weekly. Completed questionnaires were coded and held in a secure computer at the researcher's private residence while the researcher was in Japan. These data and original questionnaires were only accessible to the researcher. The completed questionnaires were given an identification number for the purpose of data analysis and preserving confidentiality.

All collected data will be destroyed on the successful completion of this study.

4.5.5 Samples and Sample Size*Phase 1: University Teaching Hospital Interviews*

The study sample for the semi-structured interviews was purposive and identified by snowballing. The samples and sample size were the following:

- Five nurse managers who were involved in an orientation programme for recently registered nurses or who were familiar with the issues related to recently qualified nurses

- 10 ward managers in ITUs/HDUs/CCUs/ICUs at the study sites where recently qualified nurses were working.
- 15 recently qualified nurses registered for 24 months or less who had graduated from the university working in ITUs/HDUs/CCUs/ICUs at the study sites.

The recruitment of recently qualified nurses was limited to graduates from university as the Scottish recently qualified nurses were all university graduates. The sample size for interviews in Japan was decided based on the sample size for the Scottish study.

As noted (4.4.4), in this study, RQNs were defined as nurses registered for 24 months or less. In addition, RQNs were defined to include RNs with various length of experience as hospitals only employ newly graduate nurses once a year, usually in April.

Phase 2: University Teaching Hospital Questionnaire

The sample for the questionnaire was purposive and obtained via convenience sampling to meet the inclusion criteria as follows:

- Registered nurses in ITUs/HDUs/ICUs/CCUs working with recently qualified nurses in one of the study sites

The exclusion criteria were the following:

- Bank nurses
- Registered nurses on sick leave or maternity leave.

The sample size of this phase was set at 200, the same as Part 1 after consideration of potential nurse numbers, the timeframe and manageability of data given that this was a cross cultural, two country study. Even though an over-sampling strategy was used in Part 1, it was not applied in Part 2 because the researcher was able to estimate the number of registered nurses who met the inclusion criteria for the questionnaire according to her previous working experience at one of the study sites. The questionnaire response rate with Japanese nurses was expected to be around more than 80 per cent according to similar questionnaire studies in Japan (Suzuki et al., 2006; Kanai-Pak et al., 2008). In addition by the time the researcher decided the sample size, she knew the response rate for the

questionnaire in Part 1 (n=118). Thus, 80 per cent of 200 potential participants was 160, which would allow the researcher to conduct statistical analysis.

4.5.6 Identification and Recruitment Process

The recruitment period was from 15/05/20010-31/08/2010.

After gaining research approval, the researcher identified and recruited potential participants for the study. Each step is described in the following paragraphs.

Phase 1: Identification and Recruitment Process: Ward

After having gained research approval from the Director of Nursing at each hospital, initial contact was made with six ward managers through Directors of Nursing Education and they asked the ward manager's permission to conduct a study in their clinical area. They were asked for their support in terms of recruiting staff nurses. A recruitment pack was sent via email and also handed by the Director of Nursing Education to each ward manager. At this point, all six ward managers agreed to participate in the study. This study was conducted in four ICUs/ITUs/HDUs/CCUs located in the two different university teaching hospitals.

The researcher asked the ward manager at the meeting for the followings:

- Their help to identify and distribute the interview recruitment package to recently qualified nurses on the ward.
- Their help to distribute the questionnaire to all registered nurses on their ward.
- Their agreement to participate in the study by being interviewed.

Phase 1: Identification and Recruitment Process for Nurse Managers Interviews

Initially, the Directors of Nursing (n=2) at each study site agreed with the interview when the researcher asked them their permission to conduct this study. They identified an additional four nurse managers at their hospital to be approached for interview. After the identification of potential participants, initial contact was made with these four nurse managers via a letter with a Study Protocol, PIS (Appendix XXX), Interview Guide

(Appendix XXXIII), and Consent Form (Appendix XXXV). The Director of Nursing Education distributed the interview recruitment package. All targeted nurse managers agreed to be interviewed. In addition, a Japanese academic who the researcher had informal interview with prior to this study identified one potential participant from the Japanese Nursing Association (JNA) and one RN person from the government. Even though Part 1 did not recruit anyone from the Royal Collage of Nursing, equivalent to the JNA, the researcher decided to recruit him as one of the potential participants. The researcher considered that including him as a potential participant expanded the variety of data within the Japanese healthcare system where hospital structure and the role of nurse managers are slightly different from Scotland. A nurse manager from the JNA was contacted initially via a letter with study protocol, PIS, interview guide, and consent form and agreed. A potential participant from the government was also included. She was the leader of the project in nursing workforce planning in the Japanese government. The researcher had an interview with nurse manager working for the Scottish governmental project in Part1, Phase 2. The researcher considered her to be in the equivalent position as a participant in Scotland. Initial contact was made as the same way as other potential participants and an interview was agreed.

Phase 2: Identification Process for Ward Managers Interviews

Ward managers (n=6) on study wards were identified by the Director of Nursing Education at each hospital. Interview recruitment packages including the PIS, Interview Guide, and Consent Form were given to the ward managers during the process of recruiting the study wards. Six managers agreed to be interviewed.

Phase1: Identification Process for Recently Qualified Nurse Interviews

Ward managers and the Director of Nursing Education at one hospital identified the recently qualified nurses who met the inclusion criteria. A total of 18 recently qualified nurses who met the inclusion criteria were identified from the two participating hospitals.

Phase 2: Identification Process for Questionnaire

Ward managers from the two hospitals and the Director of Nursing Education from one hospital site identified all registered nurses (n=180) on their wards (n=4) for the purpose of the questionnaire distribution.

Phase 2: Recruitment Process for Ward Managers Interviews and Questionnaire

Four ward managers and 18 recently qualified nurses who met the inclusion criteria were invited to the study in the following way.

1. The study protocol, PIS, questionnaire, interview guide, and consent form were given to the ward manager at the initial contact via email and/or by hand.
2. After gaining their permission and agreement, a meeting was organized at each nurse manager's office to discuss the steps the researcher would take to conduct her study on their ward and the support the researcher needed from the ward manager. There was no meeting with one ward manager because she was extremely busy during the researcher's visit to the study site. Thus a meeting was organised with the Director of Nursing Education at that study site to discuss the project.
3. During the meeting, all potential participants were identified by the Director of Nursing Education and ward managers for interviews and questionnaires. The ward managers or the researcher distributed questionnaire recruitment packages and interview recruitment packages to potential participants (nurse managers, recently qualified nurses and RNs) individually.
4. The researcher put the potential participant's name when available on an envelope and distributed individually during the staff meeting.
5. Publicizing the study to the nurses was undertaken in the following ways; the researcher visited the ward several times with permission and gave a small talk to the nurses about this study and/or the researcher attended the staff meeting. If available, written notes were put in the communication book which all nurses looked at during their shift.

The following table shows each step taken in order to gain the maximum response from all potential participants (Table 4-3).

Table 4-3: Steps to Maximize the Response Rate

	Study Site			
	H	I	J	K
Putting individual names on the recruitment packages (questionnaire and interview packages)	✓	Ward Manager declined	✓	Only interview package
Distribution of the recruitment package individually face to face by ward manager	✓	✓	✓	✓
Distributing the recruitment package individually face to face by the researcher	✓	✓	✓	✓
Researcher giving a small talk about this study to nurses on the ward	✓	✓	✓	✓
Attended staff meeting	✓	✓	✓	✓
Writing notes in the communication book	✓	✓	✓	✓
Researcher sends reminder letter to the each ward before the return date of the questionnaire	✓	✓	✓	✓
Researcher sends reminder letter before the due day for the interview	✓	✓	✓	✓

When the researcher was distributing the interview recruitment package at one study ward, two recently qualified nurses were no longer working on that study ward. Thus a total of 16 recently qualified nurses were recruited.

Two ward managers declined to put names on envelopes because it made it difficult for them to distribute the questionnaire to the nurses.

The reminder letter was not sent to each potential participant for the questionnaire. The researcher discussed with three nurse managers and nurses with recent working experience at the study sites. They advised that it was not culturally acceptable behaviour to send each potential participant a reminder letter. Thus the researcher decided to send the reminder letter to the ward and asked the ward manager to put it in the communication book so that everyone could look at it and this was done.

4.5.7 Data Collection Tools

Interview Schedule

There were two different interview schedules; one for nurse managers including ward managers (Appendix XXXIII); and one for recently qualified nurses (Appendix XXXIV). These interviews were initially developed in English for Part 1 (Appendix XII and Appendix XIII) and then translated to Japanese (4.5.1). At this point, several questions were omitted from translation because the contents were not appropriate for Japanese interviewees (e.g. asking about 'FS' or 'ECCFs'). Additionally, several original questions from the English interview schedule were combined or amended to make it easier to follow for Japanese interviewees. Thus the numbers of interview questions in some schedules were different from the Scottish interview schedule. After translating the original documents to Japanese, back-translation was applied to these documents. The content of back-translate interview guides were discussed with the supervisor and the researcher made some amendments according to the discussion.

The interview schedule for nurse managers including ward managers was composed of two parts. The first part consisted of five questions (Q1-Q5) (similar to Q1-6, see Appendix XII) to probe their perceptions, opinions, concerns and issues related to government policies and legislative changes regarding nursing workforce planning. After these questions, the second part focused on their perceptions and opinions about the most recent legislative changes in the 'Nurse Provision Act' and 'Public Health Nurses, Midwives and Nurses Act' in 2009. Seven questions were asked in total. The first two questions (Q6-Q7) were about their expectations and perception of legislative change on 'Nurse Provision Act' and 'Public Health Nurses, Midwives and Nurses Act' in 2009 (similar to Scottish interview Q7-8, see Appendix XII). The next question (Q8) aimed to probe the outcome and changes due to these legislative changes on the ward and recently qualified nurses (similar to Scottish interview Q9-10, see Appendix XII). The following questions (Q10-Q11) were about their unique programmes at their hospitals and any concerns and issues (similar to Scottish interview Q11 and Q13, see Appendix XII) and the following question (Q11) asked about possible different approaches to the issues related to recently qualified nurses.

The interview schedule for recently qualified nurses was composed of two parts. The first part probed their experiences of being a recently qualified nurse (Q1-Q5) (similar to

Scottish interview Q1-5, see Appendix XIII) while the second part was aimed at their experience of the orientation programme at the hospital and support (Q6-Q9) (similar to Scottish interview Q6-15, see Appendix XIII). The last questions were about their concerns or recommendations for other recently qualified nurses.

Construction of the Questionnaire

The Japanese version of the questionnaire was developed based on the English version of the questionnaire.

The Japanese version examined the impact of government policies related to recently qualified nurses; on the nursing workforce at local level with critical care nurses and to provide a general view of the nursing practice environment in Japan. The questionnaire included the same component as the Scottish version of the questionnaire, including participant demographics and three further sections: in relation to change to their work place; in relation to experiences as a recently qualified nurse; and in relation to their working environment.

The original (Scottish) version of the questionnaire was translated into Japanese by the researcher and then back translated by bilinguals. After checking the contents of the questionnaire with the supervisor, the researcher also asked some native Japanese speakers who had some nursing background to feedback on the content and the wording of the questionnaire. In this way the validity of Japanese content of the questionnaire was established. In this section, only the differences from Scottish arm are described.

The first part of the questionnaire was about demographic data. The answers for the educational background were originally added to the English version as the Japanese nursing education system is different from Scottish one.

In Section 1, perceptions of workplace change were measured by using the POWCS (Perception of Workplace Change Schedule) (see 3.8.1.) The last question asking about their involvement in the ECCFs and FS programmes or project targeted at recently qualified nurses was omitted as there is no such a programme in Japan.

Section 2 was designed only for recently qualified nurses to complete. In this section, experiences of being recently qualified were explored. Several questions asking about their

involvement in and their satisfaction with 'FS', 'ECCFs' were omitted from the Japanese version of the questionnaire.

Section 3 was designed for all registered nurses to complete. In this section, their perceptions of the hospital nursing practice environment were measured. There are Japanese studies used the NWI-R (Nursing Work Index Revised) (Kanai-Pak, 2007; Kanai-Pak et al., 2008). Thus the translation of the PES-NWI was done based on the Japanese version of NWI-R used in the previous studies (Kanai-Pak, 2007; Kanai-Pak et al., 2008) because PES-NWI was originally developed from NWI (Kramer and Hafner, 1989) and NWI-R (Aiken and Patrician, 2000) was revised version of NWI. Back-translation was therefore not necessary. However, the wording of the questionnaire from the Japanese version of NWI-PES was compared with the original version and discussed with the bilinguals who did the back-translation for other research documents. In particular the word and content was compared and discussed where the researcher made changes in the questionnaire for the Scottish arm. The researcher decided to use the phrase from Japanese version of NWI-R rather the phrase from the Scottish questionnaire for this part. For example, 'Adequate support services allow me to spend time with my patients' was used where it was rephrased in Scottish questionnaire to 'Our hospital believes that it is important for me to spend time with my patients'.

4.5.8 Pilot Study and Pre-testing Data Collection Tools

Pre-testing of the data collection tools and pilot interviews was conducted with the mentor in Japan and three nurses working at the study sites

- To examine the wording of interview questions in terms of participants' understanding.
- To examine the order of questions in terms of participants' understanding.
- To give the researcher experience with the interview procedure and to improve the researcher's interview skills and overall performance in Japanese.
- To test the quality of recording equipment.

- To examine the quality of recorded data for data analysis with different computing settings.
- To examine the wording of interview questions and the questionnaire in terms of participants' understanding.
- To estimate the length of time to complete the questionnaire.

Phase 1: Pre-testing Interview Schedule

The interview schedule for Phase 1 was given to the mentor and discussed. Pre-testing was conducted with the mentor in Japan. Several suggestions were made on interview questions as the mentor thought these questions were difficult to answer for some nurse managers. The order of interview questions flowed smoothly from one question to another question.

Phase 2: Pilot Interviews and Pre-testing Interview Schedule and Questionnaire

The pilot interviews for Phase 1 were conducted with three nurses working at one of the study hospitals. One was a ward manager at an accident and emergency unit with recent working experience in the intensive care unit as a ward manager. The other two were registered nurses with recent working experience at the study site and one had experience of being a clinical educator. The researcher had personal contact with them. Thus they were recruited directly by the researcher. The pilot interview was conducted either in their office or in their private room. These pilot interviews were recorded for the purpose of testing the quality of recording equipment and the operating system because the researcher had to use a different computer to the one she used in Scotland.

Pre-testing of the questionnaire and the interview guide was conducted with 15 nurses and ward managers working at one of the study sites. Their nursing backgrounds varied so that the researcher was able to gain feedback from nurses with various backgrounds and different perspectives. The interview guide (n=10) was distributed to six ward managers and five recently qualified nurses at the study sites. The questionnaire (n=10) was distributed to nurses at study site hospitals. They were asked to give feedback about the contents and the length of the time to complete the questionnaire.

Findings were as follows.

- The researcher was able to familiarise herself with the interview process in Japanese. The researcher did not feel any stress or anxiety because the researcher had personal contact with the interviewees before. Good feedback was given to the researcher in terms of overall interview performance.
- The recording equipment worked well and the transference of recorded data into the personal computer was also successful with a different computing environment although it took much longer to transfer compared to Scotland.
- The quality of the transferred data was good enough for data analysis.
- Participants commented on several questions that were difficult to answer. They gave the researcher advice to give participants some examples at the actual interview so that these questions would be easy to answer.
- Most of the feedback for the contents of the interview guide and questionnaire was positive and favourable.
- Both the interview guide and questionnaire were understandable and easy to follow. However, several comments were made on the interview guide for nurse managers that some interview questions were difficult to answer because there was no example. Thus minor amendments were made to the interview questions for the nurse managers. The researcher added some extra explanation to the interview questions during the actual interview.

Overall Summary

The researcher was able to establish interview skills and familiarise herself with the interview environment in Japanese. A few changes were made in order to maximise the understanding of the interview questions for the potential participants. All pilot study data were excluded from the main study data analysis.

4.5.9 Data Collection Process

Conduct of Interview

Interview appointments were usually made via emails or face to face. All interviews started after the researcher introduced herself and explained the study briefly. Participants were then asked to sign the consent form. Interviews with academics were held usually at their office or in an available room at the hospitals where the participants were working at the time of the interviews. Interviews with nurse managers and ward managers were mostly held in their office or in an available room at their hospital or the organisation. The interview time with nurse managers and ward managers varied from 28 minutes to about an hour. Interviews with recently qualified nurses were held mostly at available rooms at their hospital. The interview time with recently qualified nurses varied from 23 to 29 minutes. In terms of digitally audio recording, all participants agreed to be recorded and none of them withdrew from the interview.

Most of the interviewees seemed to be relaxed and comfortable with the researcher. However, some of the recently qualified nurses seemed to be nervous and some of them mentioned that they were nervous. In that case, the researcher explained again the purpose of the study and the participation in this study was voluntary and that they were always able to withdraw at any time. None of them withdrew the interview. As the interview proceeded, they started to be relaxed and talk more fluently.

Field Notes

Field notes were taken after the each interview in order to gain depth understanding of the interviews. The researcher used same developed template for the field note that used for Scottish interviews (Appendix XXI).

4.5.10 Data Analysis of Interview Data

Data analysis of interview data was conducted in Japanese. The process of data analysis followed the same way as Part 1(4.4.9). The data were not translated into English at this point.

Transcribing

The digital audio recorded interview data were transferred to a secure computer at the researcher's residence. Verbatim transcribing was undertaken shortly after the interview by the researcher. The researcher would go through the recorded interview once with the initial transcription was completed to ensure the transcription was accurate and a valid reflection on the whole content of the interview. In this way, transcriptions were checked to ensure they were valid reflection on the whole content of the interview.

Translating Findings

Translation is the important part of this research to maintain the richness of meaning in the original language. The original language, Japanese, was used for Part 2 data analysis. The findings from the interviews were translated after completing all data analysis to secure the accuracy of translation. Firstly, the themes and categories were identified from the original Japanese interview data. A set of findings, themes and categories, in Japanese were then briefly discussed with the mentor in Japan. After that a set of findings were translated into English and then discussed with the researcher's supervisor in UK.

The researcher translated all of the data and findings for this study. This brought benefit to the accuracy and consistency of the translation. Firstly, the consistency of the translation was established by only the researcher being translator. Secondly, the researcher had advantages that she was able to understand the language and the background of the culture. Thus it was easier to translate and abstract the meaning in the cultural context. On the other hand, the researcher faced the challenge of keeping the richness of meaning in the original language as it was difficult to translate some unique Japanese expression and diction.

4.5.11 Data Analysis of Questionnaire Data

Data analysis of questionnaire data followed the same procedure as the data analysis with Scottish Data (4.4.10).

Chapter 5: The Findings of Interviews

5.1 Introduction

Semi-structured interviews were conducted to answer research questions 3 and 4 (to explore the responses to the policies and issues related to policies at the local level). In this chapter, the findings from interviews are presented. After the transcriptions from the Scottish and Japanese parts of the study were done, a ‘tree node’ was used to provide the reflective labels and then the data were categorised into bigger groups (sub-categories) (4.4.8). Themes emerged after grouping the sub-categories into bigger groups (categories). The interview data from Part 1 were analysed first and then data from Part 2 were analysed. For the purpose of a clear understanding of this study, findings from Part 1: Scotland and Part 2: Japan are presented separately by sample groups: nurse managers, ward managers and recently qualified nurses. Then a comparison is made between Scotland and Japan. The following table shows the study design and the participants in each phase.

Table 5-1: Study Design and Number of Participants

	Part 1: Scotland	Part 2: Japan
Phase 1 Interviews (n=43)	NHS Managers (n=5)	Nurse Managers (n=7)
	Ward Managers (n=7)	Ward Managers (n=6)
	Recently Qualified Nurses (n=9)	Recently Qualified Nurses (n=6)
Phase 2 Questionnaires (n=202)	Registered Nurses at ICU/CCU/HDU (n=119)	Registered Nurses at ICU/CCU/HDU (n=83)
Data Collection Period	07/2009-03/2010	04/2010-09/2010

5.2 Part 1 Phase 1 Scotland

Part 1 (Scotland) data were from 21 interviews: five with NHS nurse managers, seven with ward managers, and nine with RQNs (three of them were involved in ECCFs and all of them were involved in FS). The length of the interview ranged from 11 minutes to 45 minutes. The interview data were analysed in separate sample groups: nurse managers

(NM), ward managers (WM) and recently qualified nurses (RQN). Table 5-2 shows the set of findings from interview data from Part 1 (Scotland). The respondents from the Scottish arm have 's' in the front of the identification, for example, *s*NM (NHS nurse managers from the Scottish arm). Themes are presented and described in order to reflect the interview flow and content to provide the reader with a comprehensive understanding of the findings of this study.

Table 5-2: Themes and Categories of Interviews from Part 1 (Scotland)

Sample Group	Themes	Categories
Phase 1 NHS Nurse Managers (n=5)	Policy Implementation	<ul style="list-style-type: none"> • Policy Goals and Approaches • Engagement • Implementing Initiatives into Clinical Practice
	Expectations and Perceptions of ECCFs and FS	<ul style="list-style-type: none"> • Structured Support • Motivated and Enthusiastic • Staying in the Clinical Area
	Misfit between Policy and Practicality	<ul style="list-style-type: none"> • A lot of work to do • Awareness and Involvement • Support and Resources • Doubt about the Initiatives
Phase 1 Ward Managers (n=7)	Change	<ul style="list-style-type: none"> • Policy Implementation • Doubt about Policy Change
	Expectations and Reality	<ul style="list-style-type: none"> • Support • Enthusiastic and Committed ECCFs Fellows • Doubt about the Practicality and Effectiveness
	Coming into Nursing Practice	<ul style="list-style-type: none"> • Recruiting the 'Right Candidate' into Nursing • Change in Pre-Registration Nursing
Phase 1 Recently Qualified Nurses (n=9)	Experience of being a Recently Qualified Nurse	<ul style="list-style-type: none"> • Appreciation of the Work Environment • Transition Process • Support through Transition Process
	Contrasting Perceptions and Experiences	<ul style="list-style-type: none"> • ECCFs are a Good Opportunity and Challenging • FS is Boring and not Helpful • Lack of Understanding

5.3 Part 1-Phase 1: Scotland NHS Nurse Manager Interviews

In the following sections, findings from interviews with NHS nurse managers are presented in themes and categories. Three themes and categories emerged from the interview data with NHS managers. Each theme and category (Table 5-3) is described with quotes from the participants.

Table 5-3: Themes and Categories for Scotland Phase 1 NHS Nurse Manager Interviews

Sample Groups	Themes	Categories
Phase 1 NHS Nurse Managers (n=5)	Policy Implementation	Policy Goals and Approaches Engagement Implementing Initiatives into Clinical Practice
	Expectations and Perceptions of ECCFs and FS	Structured Support Motivated and Enthusiastic Staying in the Clinical Area
	Misfit between Policy and Practicality	A lot of work to do Awareness and Involvement Support and Resources Doubt about the Initiatives

5.3.1 Policy Implementation

Based on the perceptions and experience of NHS nurse managers, the theme ‘Policy Implementation’ emerged. This theme referred to participants’ understanding of the implementation of current government policy in NHS Scotland. Three categories are incorporated: Policy Goals and Approaches, Engagement, and Implementing Initiatives into Clinical Practice. Most participants reported that they had a certain level of understanding of policy background, policy goals and what they were supposed to bring to clinical practice.

Policy Goal and Approaches

‘Policy Goal and Approaches’ refers to nurse managers’ understanding and perceptions of policy background and policy objectives. Most interviewees shared the idea that government policies were to ensure quality of care. One emphasised the principle of NHS services to the public. As she said, “*Ultimately, irrespective of which government is in power in Scotland, what they want to ensure is that they are delivering a quality health service to the population of Scotland and it’s a service that the population of Scotland want.*” (sNM 2)

Other participants perceived government policy as being more consistent than in the past.

“Certainly there is foundation of policy which gives you a chance to look at strategies across the board. There is a consistency for all the health boards..... whereas before Glasgow implemented very specific policies, not really buying into the national picture. But it is more nationally driven and we are looking at how we can be consistent.”

(sNM 1) In contrast it was thought that, *“All these policies bring out a lot of changes because we’re now ...integrating them into the work place and ...there are so many policies.”* (sNM5)

The participants felt government approaches had changed from being paternalistic and autocratic to being more patient-driven. As one explained: *“I think the change over the last 10 years is that the administrations are actually saying we need to be delivering a healthcare service that is what the general public want.....That move from being paternalistic and quite autocratic and saying we know what is best for you as the patient, rather than saying to the patient, these are the choices, so what do you want to do? And that’s been quite a difficult change for some staff.”* (sNM 2)

Engagement

Engagement emerged as a key concept to the implementation of government policy into [their own] clinical practice. Some participants believed that policies needed to be understood among health professionals. One emphasised the importance of nurses as they are the biggest professional group within the NHS and they play a critical role in achieving policy goals. *“I think that one of the major changes is that they [nurses] are now quite explicitly involved in policy and that is informing nursing workforce planning initiatives and decisions.”* (sNM 2)

This respondent identified engagement and maintaining communication as key factors to implementing government policies. *“We have to ensure we have strategic engagement within the Scottish Government Health Directorate, and then we have to move down the structure of the health service in Scotland... at the board level, operational engagement and maintaining the lines of communication - keeping people informed about the initiatives, what are the changes that have been made, what are the outputs from that It’s about ensuring that we’re embedding it [policy] and implementing it at that operational level.”* (sNM 2)

Another participant pointed out that resources were important to achieve goals. *“You can’t just have policies and initiatives without having people on the ground, like me and the team I work with, to push forward the implementation with the health boards. So they do need to follow up with some investment.... otherwise it won’t happen.”* (sNM 3) In contrast, the importance of being realistic as to what you could achieve was emphasised. *“From a management point of view, managers will be concerned about budgets and money and all that, whereas the people on the floor, it’s about their shift pattern, it’s about staff development ... You have to be realistic.”* (sNM 4)

One identified a possible concern related to financial pressure from several government initiatives. *“In programmes like Flying Start and Early Clinical Career Fellowships..... the idea of having a highly motivated, highly educated and well supported staffconflicts with the fact that financially we cannot support them.....The policies have been an excellent tool to say this is what our workforce needs and this is how we are going to deliver it [but] we can’t get staff out to be educated.”* (sNM 1)

In contrast, one participant perceived these financial challenges as good opportunities to be inventive and innovative. *“I think we have to be realistic.....We know the budgets are going to have to be reduced..... Sometimes when we have, in the public sector, reduced availability of funds, that can actually be a catalyst for innovation and we can start to think outside the box and be a bit more inventive and innovative.”* (sNM 2)

Implementing Initiatives into Clinical Practice

Several spoke about how changes were brought into the clinical area by government policies e.g. ECCFs and FS. One described how their role, the Practice Education Facilitator (PEF), came about. The PEF role *“was a big change ... primarily through [government] strategies ... to support the clinical learning environment, to support staff in developing mentorships, and how we could put in place a more robust structure for supporting the students There was a big gap between what happened out in service and what the university staff could provide in support.... We come from the clinical environment. We’re not part of the university but it’s very much about how our mentors support the student.”* (sNM 1) But PEFs also supported staff in specialist areas in an effort to retain them over time.

Another PEF described his role in relation to FS where he provided information about FS, distributed materials and organised workshops for senior charge nurses about FS. *“With the Flying Start programme, we probably engaged in a few different levels ... We would demonstrate the website, how it would work and how we thought it would help the new start person ... So we have started running workshops for the senior charge nurses.... and they link it back into their senior charge nurse review so it addresses some of their objectives.”* (sNM 1)

Summary

The general view of government policy goal was shared among NHS nurse managers. Government approaches were perceived relatively positively and the respondents were aware of changes brought about by these government initiatives. However, some respondents perceived the recent economic recession as a challenge to the NHS, while another described this challenge as an opportunity to be innovative and inventive. They were aware that engaging with policy is the key factor to achieve government goals. However, being realistic was also emphasised. In clinical practice, there were new roles introduced in the last 5 years, such as the PEF and Practice Educator, and these played an important role in the two programmes, ECCFs and FS.

5.3.2 Expectation and Perception of ECCFs and FS

Based on the participants’ understanding and experiences related to government policies related to RQNs, the theme ‘Expectations and Perceptions of ECCFs and FS’ emerged. There are three categories associated with this theme: Structured Support, “Motivated and Enthusiastic” and “Staying in the Clinical Area”.

Structured Support

The idea that FS provided structured support for newly registered nurses was shared among most participants. One commented on government intentions towards FS initiatives. *“The ultimate aim of that programme is to support the newly qualified nurse and midwife in that transition from being a student to becoming an accountable registrant for their action... The really important thing about Flying Start is that it has to be contextualised to their working environment ... It’s actually being seen as being supportive to them and the environment that they are working in.”* (sNM 2) Another government intention was to

nourish more rounded professionals by these programmes. One said. *“I think they’ve [The government] done it to make nurses more rounded professionals together with an overall view rather than just focusing on clinical to make a full practitioner, for future careers and thinking about wider issues in nursing and everything around about that.”* (sNM 5)

Another identified the attractiveness of the FS programme. *“Flying Start is a good way of support...I think the attractiveness is about that support structure, who you talk to, how to redevelop your skills...So it’s somebody there to help you with that.”* (sNM 1)

FS was often combined with a competency programme in the clinical area and used for all staff new to that area of practice. *“What we’ve done is build Flying Start into it [Competency Programme] and so for each competence, we’ve aligned a benchmark to Flying Start....So it made the competency programme more rounded and also helped to get through Flying Start.”*(sNM 5)

“Motivated and Enthusiastic”

“Motivated and Enthusiastic” was the term used by the NHS nurse managers to describe the ECCFs fellows. One nurse manager explained the government intention of ECCFs. *“The aim of the Early Clinical Career Fellowships was to take highly motivated, highly enthusiastic nurses and midwives and expose them to personal, professional and academic development over a set period of time.”* (sNM 2) Another described nurses involved in ECCFs as very motivated and enthusiastic and also expected they would achieve what the government intended them to. *“They are very motivated individuals in that they want to get further in nursing and they care about what they do in clinical nursing. And I think they will. I think that there will be the outcomes that the government anticipated this program would deliver.”* (sNM 5)

One commented on the future of ECCF nurses. She added that they needed to be motivated even after completing ECCFs programmes. *“They will go through this personal, professional and academic development with the hope that they will then have experience and knowledge of the wider issues of the NHS to allow them to further develop at a faster rate and then be able to apply for promoted posts...They have to be responsible and motivated to apply for those posts in the future.”*(sNM 2)

After completion of ECCFs, ECCF nurses were expected to be educated and to be able to bring changes to clinical practice. *“The big goal would be, we’ve got a highly educated development workforce that can adapt to change, start looking at how the service is delivered, and can start making suggestions as to how we can be more productive and more beneficial with patient care.”* (sNM 1)

Staying in the Clinical Area

Participants had varying views on whether ECCF nurses should stay in clinical practice or not. Some knew of nurses who had already decided to leave the clinical area after completing ECCFs. Some nurse managers expected ECCFs to stay in the clinical area to improve patient outcomes while others did not. *“I do not expect them to be in a clinical area. Some of them might. Some of them already have interest in education.”* (sNM 5) In contrast, another participant expressed their expectation for ECCFs to stay in the clinical area. *“I think that initially we were keen that they remained at the patient’s bedside because we know that there is literature there that tells us that if you have an educated workforce in day-to-day care delivery, there will be better patient outcomes, so we are aware of that.”* (sNM 1) Another reported that the some ECCF fellows had decided to move on their academic career after the programme. *“There are already three people who have been identified and are going to start a move into a research role ... So those individuals are already identifying that that’s where their interests lie and where they want to concentrate their expertise.”* (sNM 2)

Summary

The respondents perceived FS and ECCFs positively. They described FS as providing structured support for recently qualified nurses. They described ECCF fellows as motivated and enthusiastic. Their expectation for these programmes varied as some expected ECCF fellows to stay in the clinical area to bring some changes to the practice while other ECCFs would look for a career elsewhere.

5.3.3 Misfit between Policy and Practicality

The theme ‘Misfit Between Policy and Practicality’ emerged from the gap between what was expected or understood about policies, ECCFs and FS, and what was actually

perceived by nurse managers. Four categories composed the theme: A lot of work to do, Awareness and Involvement, Support and Resources and Doubt about the Initiatives.

A misfit of policy and actual practice was described in their clinical area. *“The Government makes these policies, and comes out with these initiatives, and on paper they sound great, but realistically, in clinical areas it doesn’t always match up.”* (sNM 4) She added that it was not the case in their area, but she perceived that it could be the case in other practice environments: *“I think for us it’s okay because we’re such a specialised area, but I certainly can see how others would be disappointed because I think the expectations wouldn’t be matched.”* (sNM 4) Other participants provided detailed examples where nurses’ expectations of government initiatives did not match up with the actual response in clinical practice. *“In terms of the workforce tools... preparing to use the tools sometimes raises staff expectations that they are going to get a lot more staff, when in fact that’s not always the case, and sometimes it’s a case of redeploying resources, so some areas may be well off, and other areas aren’t.”*(sNM 3)

A lot of work to do

Some of the respondents used the same term “overwhelming” to describe their perception of FS and concerns related to the two programmes, ECCFs and FS. One participant emphasised that FS was getting embedded. *“I think the Flying Start is definitely becoming ingrained...They’re now supporting new people who are going through it ... Sometimes looking at it for the first time you can become overwhelmed. It’s just about cherry picking, and getting in their[government] mind set.”* (sNM 1) NHS nurse managers understood that the FS was beneficial, but identified that the amount of work the nurses needed to do to complete the programme could be an issue. *“I was chatting to one of the girls the other day who said she didn’t enjoy it, she felt it was a lot of work and felt she didn’t gain that much in comparison to the competency based programme ... I would like to say the feedback is more positive, but it’s not. I think it’s because they feel it’s a lot of work and they don’t get as much out of it.”* (sNM 4)

They also added that the ECCF programme was overwhelming for newly qualified nurses even though they understood that it was a great idea. *“In terms of the Early Clinical Career Fellowship, I think it’s great in principle, but I think it’s too much for people.”* (sNM 4)

Awareness and Involvement

‘Awareness and Involvement’ was a key phrase that emerged from most of the interviews. This means the awareness and the commitment to the two programmes among RQNs, staff nurses and other people involved in the programme. One participant said. *“I think now the Flying Start programme is fairly well established. Most of the Senior Charges know about it...When they (RQNs) come into the workforce they know about it.”* (sNM 1) On the other hand, one reported that other staff nurses were unfamiliar with FS. *“None of the mentors are familiar with Flying Start, so there’s a training need and I’ve had to go through the programme with people, so they know what the expectations are.”* (sNM 4)

One participant emphasised the importance of people buying into the idea of these initiatives from the managerial to the operational level. *“It is really really important that we have the buy-in from the senior staff at board level...but it’s also really important that there is an explicit support infrastructure for these individuals from an operational point of view.”* (sNM 2) Getting people engaged was identified as an important factor for these initiatives. One said *“I think it’s getting everyone to buy in...You really need to get people to buy into it. Senior charge nurses have to see the importance. They have to identify somebody who can see the importance of bringing somebody new on.”* (sNM 1)

Despite the shared idea that involving RQNs with FS was important, lack of awareness with ECCFs and FS was reported in different contexts, for example, jealousy. Some nurse managers reported that ECCF fellows might have had experiences of jealousy from other members of staff. One participant shared her concern about other members of staff. *“I suppose my one reservation is that some colleagues feel they get left behind... I think that is one of my concerns.”* (sNM 5) Another participant also commented on how the other staff might feel about ECCF fellows. *“I think there is resentment from other staff...You’ve got these people, that they’ve been identified as being great academically, and they’re put through a Master’s, and there’s other people who aren’t getting that kind of study leave.”*(sNM 4)

Lack of involvement among RQNs was also reported as a nurse manager concern. One felt that the benefit of being involved in FS was not understood well enough; *“I think we’re not getting staff to engage...The feedback we get from the staff and people at the clinical level is that they don’t see the benefits... It’s not as positive a program as you hear from the government side...The staff at that level [clinical] don’t see the overall picture.”* (sNM 5)

Another nurse manager reported that RQNs were not very keen on completing the FS programme. *“There are a lot of people registering, but they’re never completing, and there doesn’t seem to be a great follow up.”* (sNM 4)

Despite the shared idea that involving RQNs with FS was important, several participants emphasised the difficulty due to the system and resources. *“We cannot call it compulsory. It’s very much encouraged. It is expected that they will do that...It’s strongly encouraged which means ‘yes you should do it, but we won’t give you time off or anything,’”* (sNM 1) Another participant identified time and staffing as suffocating the involvement of RQNs to complete FS. *“From a practical point of view, it’s very time consuming, and we don’t always have enough time to give to the staff because that impacts on our service if we are giving them study time to do it. It’s because our staffing is so bad just now.”* (sNM 4)

Support and Resources

‘Support and Resources’ emerged from the interviews within the context of the current issues related to FS. Some emphasised that having support from others in clinical practice to pursue the FS programme was important. One NHS nurse manager said it was key to have infrastructural support for RQNs from the board and operational level. *“It’s also really important that there is an explicit support infrastructure for these individuals from an operational point of view...Part of that is looking at the general support infrastructure within the boards, but it’s also looking at workforce planning, and how does workforce planning inform what is going on at an operational level within the NHS boards.”* (sNM 2)

However, many respondents highlighted the lack of support in terms of time for RQNs to complete FS. One commented on the lack of time given by the organisation, and the importance of providing time to RQNs to complete FS. *“From my perspective, NES [NHS Education for Scotland] isn’t giving any time. They’re not thinking about how that’s going to be managed on the floor. It does take a lot of time, and not everyone is computer literate, so sometimes it takes longer.”* (sNM 4) The lack of a firm supporting system in FS was also identified as an issue. One commented *“I don’t know of anywhere else where they are getting the staff to print off their concluding activity. Who checks who has finished it? If they don’t finish it, is it going to stop them going through their foundation gateway? No...In practice, it’s not fully supported and nobody is checking.”* (sNM 4)

Doubt about the Initiatives

‘Doubt about the Initiatives’ refers to the participants’ negative feelings and uncertainty towards the effectiveness and efficiency of ECCFs and FS. Some participants doubted if these programmes would turn out as expected. A participant made a comment on FS regarding the relationship to other programmes such as competency based programmes. *“Our staff are panicking about doing their competency based programme already, and now there is Flying Start, and it’s actually delaying them doing things like their IV administration. We’ve had to push that back and say just complete their Flying Start.”* (sNM 4)

Another participant expressed their concern on the future career pathway for Early Clinical Career Fellowship fellows. *“I also see that depending on what...on where they want their career goal to go and if those job options aren’t available at the time, where would they go then? You’ve got to think what was the career pathway everybody gets...Should this be treated any different because the government has funded it?”* (sNM 5)

Summary

Participants described their concerns about government initiatives and actual experiences and perceived a gap between what had to be done and what clinical practice could do.

5.4 Part 1-Phase 1: Scotland Ward Manager Interviews

In the following sections, findings from interviews with ward managers are presented by themes and categories and with quotes from the participants.

Table 5-4: Themes and Categories for Scotland Phase 1 Ward Manager Interviews

Sample Groups	Themes	Categories
Phase 1 Ward Managers (n=7)	Change	Policy Implementation
		Doubt about Policy and Change
	Expectations and Reality	Support
		Enthusiastic and Committed ECCFs Fellows
		Doubt about the Practicality and Effectiveness
	Before Coming into Nursing Practice	Recruiting the ‘Right Person’ into Nursing
		Change in Pre-Registration Nursing

5.4.1 Change

Based on the perceptions and experiences of ward managers, the theme 'Change' emerged which referred to participants' understanding of upcoming change in relation to the government policies and experiences of changes as a part of implementing policies in NHS Scotland. Two categories are incorporated: Policy Implementation and Doubt about Policy and Change.

Policy Implementation

'Policy Implementation' refers to the participants' perceptions and experiences of the changes that had been brought in the last couple of years, or the perceptions and expectations of the policy implementation that would be brought in the future, as well as their understanding of the policies' intentions. One participant described their understanding of policies and commented on things that nurses were expected to implement in the policy. *"I think it's about making sure that the workforce is prepared. Better prepared than it has been, so that we can deliver better health and better care...I think the responsibility is being put down to the senior staff to ensure that their team is better prepared ... Making nurses more autonomous, making them aware that they are responsible for taking things forward."* (sWM 5)

In order to implement government policies, nurses were expected to understand the policy background. One emphasised, *"With any implementation...you've got to have an understanding behind it, you've got to know why it's there, how it's going to benefit your unit, how it's going to affect your unit, how you're going to bring your team along with you...So there is always quite a large proportion of time; it's not just something that's easily established and set up."* (sWM 6)

Nurse managers were aware of coming change due to implementing policies. *"Obviously we need these policies because the nursing workforce is changing. It is certain that critical care is going to change. With workforce planning we are going to see huge change...This is not like I have experienced before."* (WM 7) In contrast, one ward manager reported that there had not been much change so far in terms of staffing and they appreciated it. *"There has not been really much change here in HDU according to the staff...so it has not really affected me as much as it has on the wards around me, more general wards."* (sWM 1)

Some ward managers said it was not possible to implement all the policies. They perceived policies as a reminder for nurses to deliver what they were required to do. *“I think there are a lot of policies. I think you can’t implement them all. What you have to do is select which ones are most relevant to your area. ... A lot of policies help you and guide you in terms of reminding you this is what you should do ... and to certainly help you in the right direction to be able to deliver better care.”* (sWM 6) One thought that nurses were the ones who did the all work in terms of bringing changes to clinical practice. *“I think they are expected to document more and a lot more information is required on the floor. There is a lot more paper work because everybody is covering his or her own back. So there is lot of paper work. Nurses are always the ones who have to do the job.”* (sWM 2)

As a detailed example of policy implementation, ward managers talked about the Senior Charge Nurse Review, which affected their role directly, the advantages and disadvantages were reported by ward managers repeatedly. One expressed their understanding of this initiative. *“Basically what they want us to do is to be back out on the floor, being visible and so on... you are not counted in numbers. Their advice is we do not take a patient group any more, but we’ve got to know all the patients.”* (sWM 1) Another described changes positively: *“I think for the Senior Charge Nurses, things have been devolved to them that they didn’t have before. Things like there are more expectations of the Senior Charge Nurses, what they are to manage.”* (sWM 5)

Doubt about Policy and Change

‘Doubt about Policy and Change’ refers to the participants’ negative views and uncertainty towards the effectiveness and efficiency of government policies. A concern about the policy-making process and implementation was reported. One perceived that the staff at the ward level were not included in the process. *“Sometimes I feel there are implementation groups set up and the policies are not involving the people who work on the floor level who probably have to implement most of the policies.”* (sWM 6)

One described how she perceived policy: *“A lot are window dressing, and to please the public and make politicians look good. I am not saying that there does not need to be an improvement...There is a tremendous amount of waste ... So all these things look good on paper, rationalising everything to make sure it is cost effective for the NHS. Grass roots actually generate a huge amount of waste and huge amount of work.”* (sWM 2) Another expressed a similar opinion that policies were to satisfy public opinion. *“I think in many*

ways they are very good. I think Flying Start is a great initiative to support staff coming in, but a lot of them I think are there to appease public opinion, to try and help the workforce but without a great deal of direction because people are sent away on these courses, and come back but people don't then see a visible difference. It is almost seen as a ticked box exercise.” (WM 6)

Uncertainty of the policy implementation process was also reported. One identified the difficulties to do what they were expected to do from the government. *“From my perspective, my job is predominantly managerial or secretarial. I am expected to be out there, and be clinically focused and leading the team and supporting junior staff and a large part of the time I cannot do that, because I am the responsible person for the ward to make sure it's governed [run well]. I might work predominantly here [office] for when I should be out there.” (sWM 2)* Another identified similar issues due to their workload after policy changes. *“I think there are a lot of bad things as well because we have not taken on somebody to take some of the workload that nurse managers had. I can see where they are coming from, and I can see the ward makes us more visible because you know... the better care the patients ultimately receive. But there has to be someone that takes away. I found that very difficult.” (sWM 1)*

Summary

Ward managers understood the benefits, but they had some difficulties and doubts about how government initiatives and changes were brought into the ward level.

5.4.2 Expectations and Reality

The theme ‘Expectations and Reality’ emerged from what was expected or perceived about ECCFs and FS and what was actually experienced in relation to ECCFs and FS by ward managers. This theme represents the gap between expectations and experienced reality. A total of three categories composed the theme: Support, Enthusiastic and Committed ECCFs Fellows, and Doubt about the Practicality and Effectiveness.

Support

‘Support’ is the key perception for understanding FS among ward managers. FS was understood to provide support and opportunities for recently qualified nurses to progress.

One participant described their perception of the benefit of doing FS. *“Flying Start is there to help them [RQNs] with the job they are doing as a newly qualified nurse... It is a good source of information ... Flying Start ... makes things much easier for the staff coming out now.”* (sWM 1) Other ward managers thought FS encouraged RQNs to build up their work portfolio and have evidence of their progress. *“I could understand that the whole point of it was to build up...the portfolio post training to get them into that mode.... They need to do it so that they can see what they’re learning. They can reflect on what they’re learning... It’s not doing extra work, it’s just writing up a bit about it so that you have learned and you have evidence that you’ve learned.”* (sWM 4) Others thought that FS filled the gap between being a student and a nurse and provided support. *“I think with university based learning, it’s very different. They are not on the wards working independently and they’re mentored, they are always working with someone. I think Flying Start...bridges that gap from being on your own and having someone support you.”* (sWM 5)

Enthusiastic and Committed ECCFs Fellows.

Several ward managers had nurses who were ECCF fellows. They perceived these nurses to be relatively positive, but they did not see any obvious difference in terms of their clinical skills. One said, *“They [RQNs in ECCFs] may be a bit more forward and a bit more enthusiastic with taking responsibility than the others. But as for their particular nursing skills, I wouldn’t say I notice any major difference, but they certainly are more forward in taking on added, extra responsibilities.”* (sNM 6) Another commented on ECCF fellows’ commitment to their work and the impact on the unit. *“Those girls are contributing greatly to the department in various ways. The benefits that I see just now are the commitment given to the unit and the work they are doing which involves the unit...They have given 100% to whatever they do. For the future, I think they will definitely go far in nursing... I definitely think that will benefit not only nursing in the future, they can cascade that to the peers, people that are coming through.”*(sWM 7)

Ward managers emphasised certain characteristics of ECCF nurses. *“I think that it takes a certain type of person to participate. I do not think everyone has the commitment to participate in a course like that... but definitely I think people that are successful and for this type of course they are handpicked and certain type of person would do that.”*(sWM 7)

In contrast to these enthusiastic and committed nurses, one ward manager noted, *“I think the thing is for new [all] graduates, we need to change the ethos. They need to do a bit*

more for themselves. I think the tendency for them is to be spoon-fed, in that they want everything, but are not prepared to give anything back.” (sWM 5)

Doubt about the Practicality and Effectiveness

Despite the benefits that were shared by ward managers, a negative perception towards FS could also be seen in the interviews. Ward managers perceived FS as a ‘burden’ for RQNs in two ways. One was time, and the other was the overwhelming work at the early stage of RQNs’ nursing careers. These two concepts overlapped as some participants talked about both together.

The difficulty of finding the time to do FS during the shift and their free time was identified. One ward manager said; *“The time they have where they can potentially do work like that (FS) is at home or nightshift. Well, would you want to be doing Flying Start in the middle of the night when you’re tired and looking after patients? It’s a really good idea in theory, but in practice it’s not the best.”*(sWM 3) Another ward manager added that a special working environment like the High Dependency Unit (HDU) made it more difficult. *“The only thing is the time. In a high dependency unit, getting time to do that is, realistically, on the floor, very difficult.”* (sWM 4) One ward manager gave an example of how many hours RQNs are required to go through their first year foundation course and emphasised the difficulty of doing FS in a specialist area like the Intensive Care Unit (ICU). *“Something like 260 hours are needed of mandatory training to get a nurse from a brand newly qualified starting to get them through the first foundation year down the line. A lot of the jobs, especially ICU, you only learn your skills when you are with patients ... Staff find it a burden to do... 150 hours for FS and the rest is all like moving and handling, mandatory, fire training, mandatory...Time that doing that means that they are not working with the patients.”* (sWM 2)

The work environment in a critical care setting was often described among ward managers as discouraging RQNs to do FS. One said, *“Staff nurses who are just starting in a new post, and because it’s a critical care area, they are overwhelmed by sick patients, by monitors, by technology, by speed, and the turnover. I think to add that in as well, they panic. As well as time, I would think that, especially for new starts [beginning] in a high dependency unit, it is overwhelming.”*(sWM 4)

Another issue reported was that government initiatives could cause confusion for RQNs and put extra pressure on them. *“I don’t think they understand how the KSF [Knowledge Skills Framework], Flying Start and the PDP [Personal Development Plan] all link together, I think it’s confusing for them ... I think it’s just adding extra pressure onto them.”* (sWM 3) One ward manager that RQNs would be interested in focusing on things that are directly related to their new job rather than things that are not. *“When they get a job, they want to focus on that and they [RQNs] want to focus on the clinical and put those books to one side. For example, if they get a job in critical care, they just want to start reading all about critical care.”* (sWM 7) Others felt the content of FS did not reflect RQNs’ interest at the beginning of their career. *“At the beginning of a career as a nurse I don’t really see the point about communication, policy, and other stuff. You will learn it maybe two or three years later... There is a lot of pressure from other people that you have to learn lots of things. So you don’t really think about the surroundings, basically focusing only on nursing, and trying to be as effective as you can.”* (sWM 3) One reported the homogeneity of FS might not fit in a specialist area like critical care settings. *“It’s supposed to give all newly qualified nurses a foundation in the first year...so that they can get through the foundation gateway. But it is homogenised to the point where there is no scope for any individualised prior knowledge or there is no scope for the differing needs of differing specialised areas. It is just...to me a complete contradiction... I mean there’s supposed to be scope for an individualised bit. There is not really.”* (sWM 2)

Summary

Ward managers understood the intention of the government programmes, but they had some negative opinions and concerns on the practicality and effectiveness of FS. In particular, the difficulty of time management among RQNs during their early stage of career was emphasised.

5.4.3 Before coming into nursing practice

The theme ‘Before Coming into Nursing Practice’ was a unique theme because nothing similar was seen in previous sections. It emerged from the descriptions of new graduate nurses’ and ward managers’ perceptions of the pre-registration course. The theme was composed from two categories: Recruiting the Right Candidate and Change in Pre-Registration Nursing.

Recruiting the 'Right Person' into Nursing

Several ward managers spoke about recruiting the 'right person' into nursing. One expected the profile of the nursing workforce would be different in the future and there might be benefits and disadvantages. *"Recruitment will be different because of the age people are coming in to do their nurse training now. So...that gives you a workforce with more life experience, which I think is better. Then we can have problems with over confidence as well, and patients are very challenging, whereas before, the way that we trained nurses and sent them out into the workforce, nurses were very subservient."*(sWM 3)

Another ward manager emphasised the important components to being a nurse and said the nursing profession is not for everybody. *"The education is important, but more and more you should never lose the compassion and the caring aspect. ... First and foremost, you should have empathy for that patient; your common skills, practical skills, and your common sense should be much greater attributes than how many letters you have after your name."*(sWM 4) She added that education is not the only way to make a good nurse. *"People went into nursing that maybe shouldn't have been in nursing. ... You'll get people going into nursing, who you wouldn't even let look after your hamster. I think it's a shame for a lot of people who would probably be fantastic nurses, but don't have the education and so on...I think we're missing that."*(sWM 4) Another thought that the government was not recruiting the right people into nursing and was excluding the right ones. *"I know it's men and women, but it is predominantly girls, and always will be. I think they are alienating a lot of people that could be good nurses; they aren't reaching out to the right people. People that are over educated, so to speak, have different aspirations for how they want to work and they don't want to be doing the 'shit-shovelling'."*(sWM 3)

Change in Pre-Registration Nursing

The change in the pre-registration programme and its impact on new nurses was described by ward managers, along with their own experience of being a newly qualified nurse. They expressed doubt about pre-registration nursing courses. *"It's a very different way from the way I was trained, and I don't necessarily think it's the right way. It's very college based. It's very degree based and sort of essay based, which, as much as I feel you need to know and understand all that, the nurses are coming into the workforce not equipped to look after [patients]."* (sWM 3) A ward manager also reported that: *"A lot of the kids don't do*

as much training in wards, there's not as much time spent on the wards as there used to be. I think that's a downside that they don't get enough ward time. I can have a staff nurse starting who hasn't done any stuff, not even a catheterisation.” (sWM 4)

Ward managers commented on the issues in the pre-registration course based on their experience. *“Whether it's been partly that the nursing programme has changed, that people are feeling there is a lot more community based rather than hospital based, that nurses felt they had a lack of skills coming out and needed more support, which has been pushed further up into the government, who have had a look at it and said more support is required in terms of training staff further. That's my thinking behind it [FS].” (sWM 6)*

Summary

Ward managers noticed the differences in how new nurses were trained and how these differences affected the development of government initiatives such as FS. Some also felt that the government might not be recruiting the ‘right person’ into nursing and emphasised the importance of recruiting the right candidates into nursing.

5.5 Part 1-Phase 1: Scotland Recently Qualified Nurses Interviews

In the following sections, findings from interviews with recently qualified nurses are presented. Two themes and categories emerged and each is described with quotes from the participants.

Table 5-5: Themes and Categories for Scotland Phase 1 Recently Qualified Nurses Interviews

Sample Groups	Themes	Categories
Phase 1 Recently Qualified Nurses (n=9)	Experiences of being a Recently Qualified Nurse	Appreciation of the Work Environment Transition Process Support through Transition Process
	Contrasting Perceptions and Experiences	ECCFs are a Good Opportunity and Challenging FS is boring and not helping Lack of Understanding

5.5.1 Experience of Being a Recently Qualified Nurse

The theme ‘Experience of being a Recently Qualified Nurse’ refers to the experiences of the transition process from being a nursing student to a recently qualified nurse (RQN), in particular a critical care nurse. The theme is composed from three categories: Appreciation of the Work Environment, Transition Process, Support through Transition Process.

Appreciation of the Work Environment

This category refers to RQNs' appreciation of their work. Several RQNs expressed how lucky they were to get their job and work in their current situation. Especially if they were fortunate to work somewhere they had known since they were nursing students. One participant said, *"I was really lucky; I was a student here for four months, and then the job came up and I got interviewed for it and I got the job. I know everybody and kind of know what the ward is like. The routine helped me certainly as a newly qualified nurse, and there was a staff nurse who also helped."*(sRQN 4) Similar comments on the work environment were also made.

One RQN described how good the support was that they got at their workplace. *"It's been good. The X [hospital name] is a really good hospital in terms of support for newly qualified nurses: I think because it's a critical care area as well, they do recognise that you do need a lot of support. As it's a critical care ward, it's always well staffed."* (sRQN 9) Another made a comment on the support they got compared to their friends who worked at a different site. They believed themselves to be fortunate to have the level of support they received at their workplace. *"Definitely, I think we are a particularly lucky case though. I have friends that work within..... and their expectations were high, they were promised a lot (of support), and what they got was very low."* (sRQN 2)

A few respondents described the experience of being in a team. *"Feeling part of the team. Being allowed to feel part of the team. If you feel part of the team, then you feel more comfortable about the experience."* (sRQN 2)

Transition Process

This category emerged mainly from the question, 'How have you found the last 24 months in terms of familiarising yourself into clinical practice as a nurse?'

A few RQNs reported their first couple of months as being newly registered nurses as terrifying and of being worried. One participant described the beginning of their nursing career as overwhelming and frightening. *"At the beginning, it was really really hard... I felt very pressurized with it and just overwhelmed at how much I had to learn. Generally, it was quite frightening."* (sRQN 8) Even though they had support from others at that time, they found it a hard time to go through. *"I've found it terrifying, and really exhilarating at times. I had a lot of anxiety dreams for the first 8 months...When I'm in the unit sometimes I feel out of control, I need to take deep breaths, tell myself that it's okay."*(sRQN 2)

In contrast, others reported an improved situation on becoming a nurse due to the experiences that they had and things they had learnt. One RQN described herself as being more comfortable and understanding more. *“I think now I feel more comfortable where I work, and I feel like I understand a lot better and I do not need to pressure people so much, ask questions whereas now I can stand my ground and just get on with it.”* (sRQN 8) Another reported feeling still unsure about certain things. However they also received reassurance from others, which helped them build their confidence. *“You still feel unsure about lots of things because you have so much to learn...but you get plenty of reassurance that you are doing okay, so you feel kind of confident.”* (sRQN 1) They added that having colleagues who are as newly qualified as they were, helped their transition process. *“It does help. It is funny...because you can kind of help each other along. It is good to start with someone definitely.”* (sRQN 1)

Support through Transition Process

As support from the workplace and other staff were described briefly in the previous category, ‘Support through Transition Process’ emerged separately from the previous category. It refers to the support that RQNs received from other members of staff and their workplace in order to ease their transition process. They described the support they had received from work with detailed examples and their perception of workplace support including being supernumerary.

Most had been supernumerary for between 4 weeks to 3 months. One who was supernumerary for 3 months identified. *“3 months supernumerary. I was out with the numbers of staff, so I was not counted. So I always worked alongside someone just because I am newly qualified. Doing that made a transition...After the 3 months, I felt ready to be by my own.”*(sRQN 1)

In contrast, one RQN reported that she did not get a supernumerary period because she had experience on the ward before as a student but thought it would have been better if there was more supernumerary time. *“I did not really get to be supernumerary to be honest because I had been here before. I think I should have. My friends never really got supernumerary time. They’re supposed to have...I think you need it when you first start. I think a wee bit more supernumerary time would help just to ease yourself in especially when you have not been in the place before.”* (sRQN 4)

Another commented on the length of the supernumerary period. *"I expected to be supernumerary for a lot longer...In a lot of critical care areas, it's 3 months... I was quite surprised it was only 4 weeks. I think I could have done with a little longer on supernumerary."* (sRQN 9)

Some expressed their concern about the support in different care settings. They shared the idea it might have been worse or it might not have been as good if they had been somewhere else other than in critical care. One said, *"I don't think I was expecting all that from the NHS. I think if I had worked anywhere else, I probably wouldn't have got much support."* (sRQN 3) However, others thought there was not enough support. *"I think on a day to day basis, support is very good in the unit because there is a nurse in charge and you never feel totally on your own. But I just think generally in a sort of nursing unit, I would like to have seen more compassion [from senior staff] or just encouragement, which you do not really get. I do not think there is enough support. I think, especially newly qualified nurses, any nurses need your assurance, need something for confidence. We have no way of knowing if we are up to the standard they expect."* (sRQN 8)

Having known other members of staff and fitting into the team were described by RQNs as one of the key features of familiarising themselves into clinical practice, as well as receiving support from other members of staff. Some described the other staff in their ward and how helpful they were. One participant described another member of staff as nice and amazing because she able to ask her anything. *"Support and team and everything here is really amazing. Everybody is really nice and even after the 3 months, there isn't anyone I can't approach to ask something and they are really nice and a good team at that."*(sRQN 1) Another RQN commented, *"The ward manager is very welcoming of questions and is willing for you to push yourself as and when and if you feel able. She is very very good ... She's excellent for support... so kind of modelling [for me]."* (sRQN 2)

Summary

RQNs experienced difficult times in their transition period. A few respondents perceived themselves lucky to be in their current job and they enjoyed being a nurse. RQNs had various levels of support from the ward and staff and they appreciated having good supportive staff.

5.5.2 Contrasting Perceptions and Experiences

The theme 'Contrasting Perceptions and Experiences' emerged from the feedback from RQNs about ECCFs and FS. There was a distinct difference in feedback about ECCFs and FS; generally, positive feedback for ECCFs and negative feedback for FS. This theme was composed of three categories: ECCFs are a Good Opportunity and Challenging; FS is Boring and not Helpful and Lack of Understanding.

ECCFs are a Good Opportunity and Challenging

Some perceived ECCFs as a good opportunity even though it was challenging and they did not know yet what they would like to do afterwards. One participant shared her experience on their decision to apply for an ECCF. *"They [university] really advertised it [ECCFs] to us quite a lot... I thought I just wanted to get on because I'm that bit older, but part of me thought about the benefit."* (sRQN 2) Another RQN commented on her decision to apply for an ECCF. They thought the opportunity was too good to miss. *"It was one of many applications that came up. It was really pushed at university and they tried to encourage us a lot and I did kind of want to do a Master's at some point, just not necessarily a year in, but the opportunity was there and it was too good to pass up."* (sRQN 3)

The financial support was appreciated. *"I think it's something I would not be doing now if I didn't have the funding and support behind me."* (sRQN 6)

They perceived being involved in ECCFs as challenging because of the experience they had as a nurse and the amount of work they needed to do. One found difficulties in the Master's course due to the lack of experience and knowledge as a nurse: *"Sometimes, I feel I don't know enough to sit in this class with people who have been qualified for years and years, and I don't know what they are talking about sometimes. I don't know if I have the knowledge to comment on these things...and I don't know if that's through lack of experience or not."* (sRQN 3) However, they perceived these challenges as positive. One said, *"I still struggle with... 'Should I be doing this?' or 'Should I just be enjoying life?' But I love the challenge, I love learning, and there is a lot to learn from the job. This keeps me learning. I worry that if I didn't do this, I wouldn't be pushing myself as hard to learn from my job."* (sRQN 2)

They had also started to see some changes in clinical practice and themselves. One participant described their change due to the programme. They were more self aware, more confident and more active. *“I feel a lot more self aware and able to be confident that I’m doing the right things at the right time. It’s a bit of an ego boost to think that you were selected for something that not everyone was picked for. It’s nice in that egocentric, selfish kind of way! It’s pushing me to get involved in things that I would have been too shy to get involved in.”* (sRQN 2)

Another commented on the changes in her way of thinking and behaviour. *“I think it’s making me change the way I think at work...Thinking about why I’m doing something even more than I was before...I think it has given me more confidence to say to the doctors and charge nurses that this is what I think.”* (sRQN 3)

FS is Boring and not Helpful.

In contrast to the positive feedback of ECCFs, the feedback on FS was relatively negative. RQNs understood the background to FS and agreed to some degree that FS could be useful and helpful, but only under some conditions. They pointed out several issues they faced during their involvement in FS and suggested changes they would make for future improvement in FS.

Some had conflicting views on FS. *“I thought this looks really good because I enjoy using computers, but I didn’t find it good. There were maybe two sections I did find useful, but the majority of it, I didn’t find useful. It was like jumping through hoops.”*(sRQN 2)

Another commented that FS was not helpful at all but they understood that FS could help you to see what is required to know. *“I did not feel Flying Start was particularly helpful, but it certainly helps you to see what you need to know.”* (sRQN 1)

One other common remark on FS was the enormous amount of time it took. As one said, *“I was overwhelmed... I thought it was an awful lot of stuff to do. A lot of repeating everything that happened at university as well as basic stuff.”* (sRQN 4) Another participant understood the logic, but did not really feel the necessity for FS because they had a ward-based competency book to complete as a RQN. *“I can see why it has been implemented in the hospitals...but I think in our situation, because we already have a competency booklet, I felt it was a bit of waste of time... It was a burden.”* (sRQN 8)

Additionally, RQNs identified the other priorities they had at the beginning of their nursing career. There were other things that they needed to do and to learn apart from things in FS. *“Actually when you first start, you are really concentrating on the ward things you have to carry out daily. And obviously that is not listed online. So these are the things you need to do every day, these are the things you need to learn in order to work well in the ward.”* (sRQN 1) Another RQN said they would like to spend more time studying in the unit rather than doing FS. *“I think they need to cut down the amount of it ... I felt it was a lot to take on when I could have been spending that time studying in the unit and seeing things that I want to learn...I was putting the time on FS when it would have been more beneficial to study more specialised things.”* (sRQN 8)

Time management for FS was identified as one of the difficulties that RQNs faced. One participant said there was no time during their shift. *“You have to find your time by yourself...In a busy critical care unit, you do not have time ... There was no time allocated and even though it was said we should have time allocated, it was not feasible. It is not possible in the unit. It is a busy unit.”* (sRQN 8). Another RQN did FS in his spare time at home. He suggested having some study days allocated for FS so that people could complete some of the activities. *“I think it would be better if there were some study days around that, so I could basically have achieved some activities by doing that.”* (sRQN 9) In addition, RQNs understood that they needed to meet their mentor to discuss their progress through FS, but they said it was impossible to do that because of the time pressure. *“The logistics of that were impossible. You were meant to be meeting up with your mentor frequently to discuss your progress, reflect on this, and reflect on that, but that never happened. There was no way you could do it with a member of staff.”*(sRQN 2)

Most RQNs made a comment on the content of FS. They thought it was too generalised, not particularly relevant to their practice, and some thought it was repetitive. *“I think it was too generalised. Some of the questions they were asking were not related to my practice. I think you end up waffling and speaking too much about stuff that maybe was not relevant because you do not know what to write about.”* (sRQN 8) Others found the structure of FS vague and too flexible, thus difficult to complete. They knew it was for all nurses and allied health professionals, but; *“It’s not very well targeted towards nurses...It’s quite vague in that respect. I think it would have been quite useful if they provided more information for the different allied health professionals, and for nurses and different aspects of nursing... It leaves things too vague.”* (sRQN 9) RQNs thought that FS did not have a firm enough structure to support RQNs. *“I do not think there was enough structure*

in it to know if you are doing right or not, which was maybe a good thing because you do not need to repeat it or anything. But in the end there was no certificate or anything like saying 'well done' or 'this is right'. So it was quite hard to know.” (sRQN 8)

The repetitiveness of the content of FS was emphasised by some RQNs. One commented that they did not really enjoy doing it. *“I did it to jump through a hoop ... It was quite repetitive and it was quite dry. There were only 2 or 3 sections I actually enjoyed doing, but the others I had to force out. I didn't enjoy it at all.” (sRQN 3)*

Lack of Understanding

Even though ECCFs and FS had different feedback from RQNs, there was a common issue shared by these programmes. It was the lack of understanding among other members of staff. RQNs reported their experiences and perceptions that other staff did not have a deep understanding of ECCFs and FS so that RQNs could not be as well supported as they should be.

Several RQNs reported that they did not get enough support for completing FS. One commented they had the impression that nobody else at their work was really involved in FS apart from RQNs. *“Nobody is really getting anything out of it [mentors for Flying Start]. It's in nobody's interest that anybody finishes it, apart from us. There wasn't very much actual support, no one in my actual unit in work had heard of Flying Start except the educators, and they didn't have the time to be mentors. So I didn't have a mentor, which is a fairly big part of it.” (sRQN 2)*

Another RQN shared their impression that their preceptor/mentor for FS did not have enough training so they did not understand what they were required to do. *“One of the issues...that a lot of the preceptors don't seem to have had a lot of training of being a preceptor...I probably know more about Flying Start than my preceptor does.”(sRQN 9)* It has to be noted that there were some study days held in wards to increase the awareness and understanding of FS among senior charge nurses.

Sometimes the lack of understanding was reported in a different format. For example, one RQN involved in ECCFs experienced uncomfortable situations with the other members of staff. *“There are a few members of staff who... are making comments about my contract, and how they would like my easy contract and I find that really difficult. All I want to do is*

learn and do my best. It's not that I'm trying to be better than them. I just want to do better for myself, so I struggle with that." (sRQN 2) Another also had a similar experience in that their colleagues made some uncomfortable comments on their work shift due to the ECCF programme. *"I don't think it's known about as much by other people. You get a lot of people making comments in work about it, because you get time off to go to university ... sometimes there can be jibes and trying to get at you."*(sRQN 3)

The lack of understanding of ECCFs among charge nurses was also emphasised. *"My charge nurse doesn't have a clue what I'm doing...There is a lot of support from the organisation at work but I don't know if there is enough understanding further down in the organisation."* (sRQN 3) Another experienced the situation where their senior charge nurse did not understand fully about ECCF and the purpose of it. *"I have heard a senior charge nurse saying, "yes it's an accelerated development programme", and implied that it's an accelerated promotion route, which it's not. It sounds like an implication that it's a fast track to sisterhood, which it's not."* (sRQN 2)

As many participants identified issues in the lack of understanding of these programmes, some described possible changes in the implementation of these programmes in the actual ward. RQNs thought that other staff needed to be more educated about the programme in order to understand FS. They particularly talked about FS. *"In order for it [FS] to be more useful, it needs to be more understood, and it's not understood by the nurses who are meant to be acting as mentors. It's something that has been imposed from the top, and there has been very little distillation down of its purpose. So in order for it to be more useful...it needs to become more understood, more accepted, and it's what a newly qualified nurse does."* (sRQN 2)

Summary

ECCF was perceived relatively positively even though some RQNs described it as challenging. In contrast, FS was perceived rather negatively. Only a few RQNs reported that they enjoyed being involved in FS. Some of them had doubts about the structure of FS and the content of FS. Lack of understanding was a shared issue in ECCFs and FS. RQNs reported that increasing the level of understanding among other staff nurses would help as it replaces the programme to be more helpful and beneficial.

5.6 Part 2 Phase 1 Japan

Part 2 (Japan) analysed data from 19 interviews: seven with managers, 6 with ward managers, and 6 with RQNs. The length of the interviews ranged from 23 minutes to 1 hour. The interview data were analysed separately by sample groups: managers, ward managers and recently qualified nurses. Table 5-6 shows the set of findings of interview data from Part 2 (Japan).

Respondents are identified by nurse managers/nurse managers (NM), ward managers (WM) or recently qualified nurses (RQN). The respondents from the Japanese arm have ‘j’ in front of the identification, for example, jNM.

Table 5-6: Themes and Categories of Interviews from Part 2(Japan)

Sample Group	Themes	Categories
Phase 1 Nurse Managers (n=7)	Japanese Nursing and Policies	Issues in Japanese Nursing Nursing Workforce Planning Policies
	Numbers and Quality of Nurses	Impact of 7:1 Patient Nurse Ratio Doubt in the Quality of Experienced Nurses as Clinical Educators
	New Generation of Nurses	Characteristics of RQNs Theory-Practice Gap Organisational Support for RQNs
Phase 1 Ward Managers (n=6)	Expectations of Government Policy	
	New Generation of Nurses	Characteristics of RQNs Expectation of Orientation Training System
	Numbers and Quality of Nurses	Impact of 7:1 Patient Nurse Ratio Experienced Nurses
Phase 1 Recently Qualified Nurses (n=6)	Transition Process	Establishing Professional Identity Expectation and Experience Gap Relationship with Other Members of Staff

5.7 Part 2-Phase 1: Japan Nurse Manager Interviews

In this section, findings from interviews with nurse managers are presented by themes and categories. Three themes and seven categories emerged from the interview data and are described with quotes from the participants.

Table 5-7: Themes and Categories for Japan Phase 1 Nurse Manager Interviews

Sample Group	Themes	Categories
Phase 1 Nurse Managers (n=7)	Japanese Nursing and Policies	Issues in Japanese Nursing
		Nursing Workforce Planning Policies
	Numbers and Quality of Nurses	Impact of 7:1 Patient Nurse Ratio
		Doubt in the Quality of Experienced Nurses as Clinical Educators
	New Generation of Nurses	Characteristics of RQNs
		Theory-Practice Gap
		Organisational Support for RQNs

5.7.1 Japanese Nursing and Policies

The theme ‘Japanese Nursing and Policies’ emerged based on the participants’ understanding and perception of government nursing workforce policies and perceived issues related to current Japanese nursing. In particular they reported their experience of promoting the various working shift patterns and their concerns about the current Japanese nursing system.

Issues in Japanese Nursing

‘Issues in Japanese Nursing’ refers to the current situation of Japanese nursing. One participant identified the political and social value of nursing labour within the Japanese healthcare system and getting sufficient reward for the value of nursing labour as the keys to sustaining the nursing workforce. *“I think that the government is not able to evaluate the value of nursing labour objectively enough. We need a system that can reward nurses based on the evaluation of nursing labour objectively according to the quality of nursing care.”* (jNM5) Another commented that there was a need to change the payment system for nurses: *“We need to review the salary system to match the ability and experience of nurses like other health professions.”* (jNM 1)

Aspects of the healthcare system in Japan were identified as obstacles in terms of sustaining a sufficient nursing workforce. Firstly, the lack of a registration system for nurses was recognised as an issue. One nurse manager commented on the difficulty in gaining information regarding nurses’ employment status and suggested that establishing a registration system for Japanese nurses could be a solution for inactive nurses (2.6.6, Inactive Nurse). *“There is an idea of introducing a registration system. It can help us to*

know the exact number of nurses...Once you have qualified nurses, we do not know where they are and what they are doing. ” (jNM 7) Secondly, the medical care fee schedule (2.6.4, Health Insurance) was reported as an obstacle for sustaining a sufficient nursing workforce for future demand. One identified that the revisions of the medical care fee are biased because the members of the committee are mostly medical doctors who own their own clinics and focus on the financial benefit for them. “ The committee that decides and revises the medical care fee schedule for remuneration reflect mostly the managers’ perspective...I think the government responds to these managers who would like to receive more financial benefit from remuneration rather than benefits for patients or nurses.” (jNM 7)

Nursing Workforce Planning Policies

All nurse managers mentioned international recruitment. Most perceived international recruitment as one of the government policies to solve the nurse shortage issue in Japan and made negative comments on it. *“I do not really understand international recruitment. I do not have any problem about accepting foreigners. However, I think they should have done that in a different way. I do not think the policy [international recruitment] itself can produce good results straight away.” (jNM 3)*

Regarding policies related to nursing workforce planning, some nurse managers perceived government initiatives as favourable. One said, *“Recently the government has been working on the issue [nursing workforce planning] and introducing many initiatives, so I think the foundation for the system [to maintain the sufficient nursing workforce] is getting there.” (jNM 4)* Another had a favourable view on the government because she believed that sustaining and developing a sufficient nurse workforce could not be done by each organisation’s efforts. *“I have been thinking that the issues related to the shortage of nurses cannot be solved by individual hospitals, so the current government approach is very important.” (jNM 6)*

On the other hand, some nurse managers had doubts and concerns towards the government’s attempts and approaches. One thought that the government was not really working on the key issues for Japanese nursing. *“I think the most important thing is to secure a good work environment where nurses are able to work for longer. It’s not about producing more new nurses. The government is taking too long to start working on the essential issue.” (jNM 7)*

Yet another perceived government policy to be somehow contradictory in terms of nursing workforce planning. *“I feel government policies are confusing regarding nursing workforce planning policy. For example, the government left all authority for hospital management to each hospital. So hospitals are trying to be as economical as possible with low human resource costs and low investment in education. However, the government is also working on a project to improve the quality of nurses and nursing education..... I think the government does not really see these issues and we are the ones who need to sort out these problems.”* (jNM 5)

Summary

Nurse Managers perceived recent government initiatives related to nursing workforce planning as relatively positive. However, they were aware of other issues related to nursing practice and the Japanese healthcare system such as lack of a registration system for nurses and the value of nursing labour as well as integrated approach.

5.7.2 Numbers and Quality of Nurses

This theme ‘Numbers and Quality of Nurses’ emerged mostly from comments on the change of the medical care fee schedule for remuneration in 2006 (see 2.7.7.). This theme was composed of two categories; Impact of 7:1 Patient Nurse Ratio, and Doubt in the Quality of Experienced Nurses as Clinical Educators.

Impact of 7:1 Patient Nurse Ratio

Most nurse managers were aware of the changes due to the revised medical care fee schedule for remuneration. They reported, *“The number of nurses has increased.”* (jNM 1) Others commented on the change as, *“There is a big difference in the number of nurses. Several dozen nurses came into our hospitals.”* (jNM3)

Despite the perception of an increased number of nurses in the hospital, they were aware of other impacts of this revision. In order to meet the criteria of a 7:1 patient nurse ratio, hospitals recruited and employed recently qualified nurses (RQNs). One nurse manager commented on the quality of nursing care and the age profile of nurses at her hospital. *“Young nurses increased dramatically. Since then, 60% of all nurses in ICU are nurses with less than 3 years of experience. In every ward, great numbers of nurses are young*

nurses with less experience. The level of clinical skill among nurses and the quality of nursing care has decreased even though the number of nurses has increased.” (jNM 6)

One nurse manager who experienced the rapid change in nurse staffing and allocation at the beginning of implementation of staffing levels (based on 7:1 patient nurse ratio) thought that the hospital was focused on gaining the approval solely for more financial benefits rather than investment in quality nursing. *“At the beginning, it was confusing. It was not like allocating the extra nurses to the places where they needed nurses. Hospitals are very very eager to employ more nurses because they wanted the money. Ironically, there was a case where nurses were not allocated to where they really needed more nurses.” (jNM 3)*

Due to the increased number of newly graduated registered nurses, nurse managers reported that more time was needed for the other nurses to educate them. *“When you think about the nurses who are in charge of educating these new nurses, it takes more time to educate them and we do not have that much time to spare for new nurses.” (jNM 2)*

Further legislative intervention to improve nurse staffing was expected by nurse managers. One was aware of the increased number of nurses, but she also felt that it was not sufficient and there was a need to improve the work environment as well as the nursing role. *“After 7:1 approval, in clinical practice, we are not satisfied with the numbers of nurses. Some people say we need more....So we need to work more on the work environment and expanding the nursing role.” (jNM 6)*

Doubt in the Quality of Experienced Nurses as Clinical Educators

As the nurse managers talked about the changes in the medical care fee schedule for remuneration in 2006 (2.6.7.) and the recent government legislative change in the clinical training system for RQNs (2.6.7.), the category, ‘Doubt in the Quality of Experienced Nurses as Clinical Educators’ emerged. ‘Doubt in the Quality of Experienced Nurses as Clinical Educators’ refers to the issues and concerns related to nurses who were in charge of educating RQNs and the approaches to RQNs from the hospital to support the experienced nurses’ progress as a nurse educator.

Most nurse managers reported their concern about the additional workload on experienced nurses in charge of teaching and mentoring RQNs who came into clinical practice after the

revision of the fee schedule for remuneration. *“I wish we had more nurses. If we had more nurses, then the experienced nurses could have extra time to provide education to new graduate nurses. I think these experienced nurses who are in charge of educating and mentoring new graduates are under pressure.”* (jNM 4) Another pointed out the lack of support for these experienced nurses who guide RQNs. *“Half of Japanese nurses are young, in their 20-30s. I think there is no support for nurses who are in charge of leading these young nurses.”* (jNM 1)

Nurse managers perceived the changes as an opportunity to improve the quality of nursing education to RQNs. At one hospital they started to provide a course for experienced nurses to become a clinical mentor after gaining 7:1 approval and having employed many newly graduated registered nurses. *“Since 2006, we have started to provide a course for experienced nurses to be clinical mentors for RQNs because the ability of these experienced nurses as a clinical mentor was not good enough to support RQNs.”* (jNM 5)

Others emphasized that managers needed to think about how they supported experienced nurses to sustain the orientation clinical training system for RQNs (2.6.7). *“The turnover among experienced nurses who support RQNs is becoming another issue, so it is meaningless if you only think about supporting RQNs. You need to think how to sustain the support system for RQNs and how to improve the work environment so that experienced nurses can work longer.”* (jNM 7)

Summary

All nurse managers were aware of the changes due to the revision of medical care fee schedule for remuneration. After gaining 7:1 approval, the number of nurses working in their hospitals increased. However, there was a concern about the quality of nursing care and clinical skills among RQNs who employed after the revision. Additionally, the change in numbers of employed young nurses created other concerns with the ability of experienced nurses as clinical mentors and how they could educate these RQNs.

5.7.3 New Generation of Nurses

The theme ‘New Generation of Nurses’ refers to issues related to RQNs’ clinical skills and perception of government policies targeted at RQNs such as orientation of the clinical

training system. The theme was composed of three categories: Characteristics of RQNs, Theory-Practice Gap, and Organisational Support for RQNs.

Characteristics of RQNs

Generally, nurse managers perceived the current generation of RQNs to be nurtured in a more protected environment. They thought that RQNs were not able to take criticism and deal with the challenging situation when they faced the reality of nursing practice compared to the elder generation of nurses when they were RQNs. Some nurse managers thought the change in RQNs' characteristics was due to the change in the Japanese compulsory education system.

One thought that RQNs were not ready for dealing with the reality of nursing practice. *"These RQNs see themselves as a new generation and I think they have been told by others that they are the new generation....I think they are mentally not strong, and do not know how to deal with difficulties in their life because they grew up in a well-protected environment and without competition or big failure in their life"* (NM 6) Others commented: *"These RQNs, who have grown up with lots of attention and protection from their parents, do not think that treating them with lots of attention and compliments is enough...there is a gap between how they perceive themselves and how we perceive them."* (jNM 1)

Changes in society over time were considered to have influenced RQNs' attitudes towards professionalism and work. *"I think society, such as the changes in the education system³⁸ and economic status, are having a big influence on RQNs' attitudes towards professionalism and work because the way of thinking among RQNs has changed over the years."* (jNM 5)

Lack of communication skills and the vulnerability of RQNs were identified as typical of RQNs among nurse managers. One noted that RQNs had difficulties in communicating with other members of staff. *"The biggest concern among RQNs is communication with others. They are worried if they can communicate with others well or not. I think they are not good at establishing a good relationship with other members of staff."* (jNM3) Another

³⁸ Yutori Kyoiku: It started in the 1980s to introduce the different style of education approach from the cramming system of education to the experience based education system. The impact of this shift brought a big change in the compulsory education in Japan and is still at the centre of discussion among academics.

nurse manager reported RQNs' vulnerability. She perceived that the number of RQNs who experienced a difficult situation with some psychological issues had increased over the last couple of years. *"I think they are mentally vulnerable, mainly RQNs, the number of nurses who collapse psychologically is increasing due to the heavy workload and pressure."* (jNM 4)

Theory-Practice Gap

'Theory-Practice Gap' refers to nurse managers' perception of the pre-registration course and issues related to the current status of RQNs. In particular, the separation between the pre-registration course and clinical practice caused by the length and content were identified as issues that needed to be solved for the future in order to nurture nurses to meet the needs for the current healthcare system. One nurse manager emphasised the importance of continuous education for nurses from pre-registration course to post-registration *"I see a huge gap between the content of the pre-registration course and actual clinical practice...So I think there is a need for continuous education that bridges the gap between pre-registration and post-registration."* (jNM5) Another commented on the length of the pre-registration course. *"The length of the pre-registration course, which is 3 years, has not changed since the law³⁹ was established. We need to promote university level education for pre-registration courses otherwise we will not be able to meet the need of the speed of changes in medical care."* (jNM 7) The pre-registration course was criticised as RQNs were seen not to be equipped well enough to practice in the clinical area. *"Recently, nursing students do not have much clinical skill practice during their pre-registration course. I think the recent pre-registration course teaches them the concept and philosophy of nursing well, but not the actual clinical skills."* (jNM 4)

Organisational Support for RQNs

Nurse managers described changes in organisational support over the last couple of years for RQNs. All study hospitals provided orientation days on the first couple of days to all new graduate nurses to teach basic clinical skills, and training or study days during the first year of their employment.

³⁹ Public Health Nurses, Midwives, and Nurses Act (1948)

Changes in support for RQNs due to the medical care fee schedule for remuneration (2.6.7) were reported. One hospital provided a course about roles and responsibilities as a health professional as a response to the characteristics of recent graduate nurses. Another created a specific place for RQNs to practise and improve their clinical skills when they had spare time on the ward. Additionally, nurse managers thought that RQNs needed more psychological support *“Our support for RQNs, in particular, supporting the RQNs’ mental health is more common and emphasised.”* (jNM 5) Another lengthened the orientation days to provide a course about essential clinical nursing skills such as taking vital signs, blood infusion, preparing drips, drug calculation.

In addition to these changes in organisational support, nurse managers had some expectations of the legislative change related to the orientation training system for RQNs introduced in 2009 (2.6.7). They expected that the orientation training system would provide RQNs with the foundation of essential nursing care skills and knowledge. One said, *“With this new system we might be able to provide similar experience to all new nurses including these specific nursing skills... and they might be able to establish the essential foundation for nursing.”* (jNM2)

In contrast, some did not have any expectation of this system as they already had an orientation training programme targeted at RQNs before the government took action. One criticised the system saying, *“I think this legislative change is too late to introduce because we have already worked on the issues for a long time by ourselves.”* (jNM 2) Another did not expect any change to happen, but the funding would be allocated. *“I do not expect anything much. I think we are already doing the things. The only change I can think of is we might be able to claim the funding from the government.”* (jNM 4)

Summary

The nurse managers reported a change in the characteristics of RQNs and identified issues related to the content of the pre-registration course such as lack of experience of practising clinical nursing skills

5.8 Part 2-Phase 1: Japan Ward Manager Interviews

In this section, three themes and five categories emerged from the interview data with ward managers. Each theme and categories are described with quotes from the participants.

Table 5-8: Themes and Categories for Japan Ward Manager Interviews

Sample Group	Themes	Categories
Phase 1 Ward Managers (n=6)	Expectation towards	Government Policy
	Numbers and	Impact of 7:1 Patient Nurse Ratio
	Quality of Nurses	Experienced Nurses
	New Generation of Nurses	Characteristics of RQNs Expectation of Orientation Training System

5.8.1 Expectations of Government Policy

The theme ‘Expectations of Government Policy’ emerged based on the participants’ perceptions and understanding about two government initiatives, legislative change in the medical care fee schedule for remuneration in 2006 (2.6.7), and international recruitment (2.6.6).

Ward managers shared positive and negative perceptions towards government initiatives. Most agreed that there was a need at the ward level to improve the situation regarding nursing workforce planning and work environment. One ward manager said, *“I think these government attempts to improve the work environment and sustain the nursing workforce were very much needed.”* (jWM 2) Another commented *“I think what the government has done for legislative change can be appreciated because they have listened to what the other professional union was advising them for a long time. They should keep listening from clinical practice and reflect on the government initiatives.”* (jWM 1)

On the other hand, several ward managers criticised how government policies were implemented at the ward level. *“There was not much funding available for each hospital for the initiatives. I do not think they can sustain the change if the government does not put more funding into the initiatives.”* (jWM 6) Another commented on the change at the ward level. *“I have heard lots of government initiatives, but I do not think they are implemented well at the ward level. I cannot really see that happening.”* (jWM 2)

Ward managers were aware of most government initiatives and had experienced positive changes. However, some of them criticised the government for taking so long to actually work on the issues related to nursing workforce planning such as sustaining the sufficient number of nursing staff and improving the work environment.

5.8.2 Numbers and Quality of Nurses

This theme ‘Numbers and Quality of Nurses’ emerged mostly from comments on the change of the medical care fee schedule for remuneration in 2006 (2.6.7). This theme was

composed from three categories; Impact of 7:1 Patient Nurse Ratio and Experienced Nurses.

Impact of 7:1 Patient Nurse Ratio

After approval for the 7:1 Patient Nurse Ratio, an increased number of RNs at hospitals was reported. One commented, *“After the approval for the 7:1 patient nurse ratio, I can certainly see the number of RNs has increased dramatically.”* (jWM 2) The study hospitals employed mostly newly graduated nurses to meet the criteria for 7:1 approval (2.6.7). *“We increased the number of employed nurses, and most of them were young new graduate nurses.”* (jWM 3) Another experienced the increased nursing workforce due to the increased number of nurses working in the hospital. *“I think it was a good change. Suddenly we had a larger nursing workforce...We had less pressure and less workload.”* (jWM 3)

In contrast, they also experienced negative aspects from the change of the medical care fee schedule for remuneration. One commented on the uneven distribution of RNs. *“Because the 7:1 ratio was introduced suddenly and the hospitals could claim more money, the hospitals scrambled for RNs. It was good for big hospitals, but not for small hospitals where they could not recruit enough RNs.”* (jWM 1) However, doubts about the quality of nursing, of which improvement was a government intention, were shared among ward managers. One said, *“Indeed, the number of RNs increased. However, I doubt that it resulted in improved quality of nursing.”* (jWM 5) Ward managers explained their doubt on the improvement of the quality of nursing care. *“It takes a longer time for these newly graduated nurses to become a proper nurse. So the increased number of RNs does not simply result in a decreased workload per RN.”* (jWM 2) Others commented on the financial benefit. *“I felt that this 7:1 ratio was to do more with money rather than the quality of nursing care for the hospital.”* (jNM 4)

After gaining the 7:1 ration approval, some ward managers thought they needed more staff for better nursing care. *“I think the number of nurses is the big issue now, especially because we need to keep the 7:1 ratio.... We need to have more nurses...Then we could start working under less pressure.”*(jWM 2) Another commented on the number of night shift nurses. *“Because there is a regulation related to the number of night shifts that RNs are allowed to do in a month, I wish I could have more nurses. Then I would not need to push newly graduate nurses to do the night shift so soon.”* (jWM 5)

Experienced Nurses

After the revision of medical care fees, experienced nurses became one of the issues related to the revision due to the increased number of new graduate nurses coming into clinical practice. Ward managers thought some of the experienced nurses were not good enough to teach new graduates. *“We needed to educate many new graduate nurses at that time. The ones who were teaching and mentoring new graduates had a difficult time, as they did not know how to teach this many nurses.”* (jWM 3) These nurses, who were new graduates around the time of the medical care fee revision, were expected to be clinical mentors for newly graduated nurses at the time of interviewing. Ward managers expressed concerns related to these ‘experienced’ nurses. *“The nurses who started work around 2006, now they have 3 years of experience. However, every ward has an issue with these nurses because they are not clinically developed and competent enough to be a clinical mentor for new graduate nurses.”* (jWM 4)

Other issues related to experienced nurses as clinical mentors were their attitudes towards their job and to teaching new graduate nurses. One commented, *“I think experienced nurses need to change their way of teaching and mentoring young nurses. Their main drive to teach young nurses is to make their own workload lighter and less stressful....I think these nurses need to be prepared for teaching new graduates.”* (jWM 3) Another thought that the experienced nurses did not feel obligated to teach these newly graduated nurses. *“I think there is no education or culture for nurses that they all need to support the young nurses.”* (jWM 5)

Summary

Ward managers experienced the increased number of RNs working at their hospital due to the legislative change in 2006 positively, but some had doubts about the practicality of government intentions.

5.8.3 New Generation of Nurses

The theme ‘New Generation of Nurses’ refers to the issues and concerns related to RQNs. The theme was composed from two categories: Characteristics of RQNs and Organisational Support for RQNs.

Characteristics of RQNs

‘Characteristics of RQNs’ refers to the perceived characteristics of RQNs along with the change in the Japanese compulsory education system and the pre-registration course. Some ward managers experienced the change in RQNs’ attitude towards their job. *“I think many RQNs do not have much commitment to the nursing profession or their job as they did not really grow up in a poor environment or they had Yutori-kyoiku⁴⁰. They do not have the idea that this job is to pay the bills and do not see the nursing profession as a long term career.”* (jWM 2) Another commented, *“There are lots of recently qualified nurses, who were not able to decide what they would like to do, coming into critical care because they think critical care would give them benefits such as advanced clinical skills and knowledge.”* (jWM 5) The impact of Yutori-kyoiku and RQNs’ social environment was reported. *“I think they [RQNs] have difficulties with communication with others and also the relationship with older people. I think their social environment has changed compared to when they were growing up. They do not really have much experience with communicating with people other than their friends and parents.”* (jWM 6)

The change in RQNs’ characteristics as a new graduate nurse due to the recent pre-registration course was also reported. One ward manager commented, *“I feel there are more RQNs who are able to think logically....Because they have spent less time in the clinical placement, they have more time to think and they have better potential to grow.”* (jWM 2) However, another commented *“They are graduated from the university, so they are brainy. Writing an essay and report, studying, they can do them very well. So these nurses can answer the questions about the patients, but their clinical nursing skills are not that great.”* (jWM 3)

Ward managers identified the extra support RQNs needed. One ward manager said, *“I think RQNs would like to be supported with developing their clinical nursing skills. Thus we are focusing on that.”* (WM 4) Another said, *“I think they need more psychological support. When they are in big trouble, and they have no one to talk to, I am not sure to whom they could talk or consult when they do not want to talk to me.”* (jWM 3)

⁴⁰ Please see foot note 1.

Expectation of Orientation Training System

As a response to concerns with RQNs' professional commitment and ability, ward managers had expectations of the orientation training system for RQNs introduced in 2009 (2.6.7). Some expected that the orientation training system would provide RQNs with the essential nursing care skills and knowledge. *"I would like them to gain expanded knowledge with a wider viewI am hoping this orientation programme can fill the gap between the pre-registration course and clinical practice."* (jWM 2) Another expected that orientation programmes would ease reality shock. *"If they can see and experience many wards, then I think they can match up where they would like to work and what they would like to do. I think this can lower the risk of experiencing reality shock."* (jWM 1) In addition to these expected benefits to RQNs, ward managers appreciated financial support from the government, *"I think it is a good thing that the government started to pay for the nurses' orientation system like medical doctors."* (jWM 6)

In contrast, some ward managers did not expect anything positive, having only concerns. One said; *"I am not sure if I have any expectation of this new orientation training system. One concern would be if it is really going to work, and the other thing is we already have our orientation programme"* (jWM 5). Another was concerned about the staffing related to this new system. *"We are not sure how we are going to do this, but one concern is the staffing. We need to create a new role for these new graduate nurses, and we do not know if we have enough staff for that role"* (jWM 1). Maintaining the 7:1 ratio was also identified as an issue in order to introduce the new orientation training system. *"We need to include these newly graduated nurses who are on the orientation training system in the calculation of 7:1. When you think about maintaining 7:1, and keep other staff's workload at the same level, I do not think this new orientation training system is practical."* (jWM 2)

Summary

Ward managers experienced the change in RQNs due to changes in the education system and also society. On the ward, they had some expectations of the orientation training system introduced in 2009 in terms of providing RQNs with some support during their transition period, but they had concerns on the practicality and efficiency of this system.

5.9 Part 2-Phase 1: Japan Recently Qualified Nurses Interview

In this section, one theme and three categories emerged from the interview data with RQNs. Theme and categories are described with quotes from the participants.

Table 5-9: Themes and Categories for Scotland Phase 1 Recently Qualified Nurses Interviews

Sample Groups	Themes	Categories
Phase 1 Recently Qualified Nurses (n=6)	Transition Process	Establishing Professional Identity Expectation and Experience Gap Relationship with Other Members of Staff

5.9.1 Transition Process

‘Transition Process’ refers to the experiences of the transition process from being a nursing student to a recently qualified nurse (RQN). The theme is composed of three categories: Establishing Professional Identity, Expectation and Experience Gap, and Relationship with Other Member of Staff

Establishing Professional Identity

RQNs described how they established their professional identity during that process. One described her first three months. *“I struggled a lot and made a huge effort...During my first three months, I had no idea what nurses are supposed to be doing, and I was doing what I was told to do...I was very nervous every single day to go to work.”* (jRQN 2) Some RQNs started to feel more responsibility and motivation over the time. *“The first month, I thought it is reasonable that I cannot do anything, so I did not blame myself and my motivation stayed at the same level. However, after a couple of months, I started to feel responsibility and my motivation started to decrease because I was not able to do what I was supposed to do.”* (jRQN 1) Another said, *“20% of me said I enjoy this job, and the rest of me said I should not cause any trouble to the patients because I am not good enough.”* (jRQN 3) The cause of stress changed over time. One reported, *“Now I am not as tense as before, but I have a different kind of stress. The stresses I have are coming from the responsibility that I am in charge of the patients.”* (RQNs 2)

Expectation/Experience Gap

Some RQNs experienced a gap between expectation of their workplace and what they actually experienced. For some RQNs, they did not expect or choose to work in the critical care setting⁴¹. One said, *"ICU was not initially my first choice. I wanted to work in the general ward."* (jRQN 4) While another said, *"I did not really have a preference where to work, or which department to work in."* (jRQN 5) Working in a critical care setting brought RQNs some unexpected experiences. *"This is more than I imagined. Most of the patients I took care of, got better. But some of them died. I have many things I have never experienced, so this put me in a difficult situation. I did not know what to do when I encountered these situations."* (jRQN 1) Another experienced the gap between what she studied at the university and what she was required to do in clinical practice. *"There were so many things I did not know. I work in ICU for the emergency care department. We did not study emergency care that much at university."* (jRQN 2)

RQNs also experienced a gap in the organisational support between what they received and their expectations. RQNs made comments on the support provided from the hospitals. Most RQNs were satisfied with the orientation programme provided by the hospitals and other workshops. However, they made a couple of comments on the content and the length of the orientation programme. *"I wish there were more clinical nursing skill practice sessions. There was not a practice session and after that (the orientation programme) I needed to practise the nursing skills straight away."* (jRQN 2) Another noted, *"I wish we had a longer orientation programme. After the national exam board, I felt I was thrown into clinical practice without preparation."* (jRQN 1)

Several suggestions were made regarding psychological/emotional support. RQNs were given the opportunity to talk to other RQNs working in different wards. *"We had an opportunity to talk about our experiences of being a newly qualified nurse with other new graduates from different wards. But we could not really share the same experiences because our working environment [ICU] is different. We struggle with the number of treatments and interventions for one patient, but they struggle with the number of patients."* (jRQN 4)

⁴¹ In Japan, each hospital recruits RNs and they are in charge of employing the RNs, not the ward. Thus newly graduated nurses do not know where they will be allocated even though they usually are asked where they would like to be allocated.

Relationship with other members of Staff

RQNs described their relationship with other members of staff; how it changed over time and how it affected their transition process. Most RQNs reported that having a good relationship with the other members of staff and having good feedback from others were the key factors for them to get used to clinical practice. One said, *“I think it is important the other members of staff ask us how we are and how we are getting on with the job.”* (jRQN 3) Another said having good feedback from the senior nurse helped her. *“Simply, giving us good feedback on what we have done became the best motivation. I was very happy to receive this good feedback and compliments.”* (jRQN 4) Interestingly, some RQNs experienced that sharing their private life with the other members of staff helped a lot for them to have a better relationship at work.

On the other hand, some RQNs thought that the relationship with the other members of staff was difficult to deal with. One said, *“There were some staff nurses who gave me a lot of stress. I understand that they are giving me correct advice, but how they say it makes me really stressed.”* (jRQN 4) Another said the politics between other members of staff and the atmosphere in the ward was difficult to deal with and get used to.

Summary

RQN experienced difficult times in their transition period. A few respondents experienced a gap between what they learnt at the university and what they were required to do in clinical practice. The relationship with other members of staff was perceived as one of the key factors for them to get used to the job. Some of them had difficulties with this.

5.10 Comparison of Findings between Part 1 and Part 2

Comparison of themes and findings between Scotland and Japan were made for each interview group. In addition, comparisons between nurse managers and ward managers within the same country were made. Before presenting the similarities and differences between Scotland and Japan, an overview of themes and findings are presented.

5.10.1 Nurse Managers and Ward Managers in Scotland

As can be seen in Table 5-10, similar themes emerged from the interviews with nurse managers and ward managers in Scotland regarding their expectation and perceptions of policies and their impact on clinical practice, in particular ECCFs and FS. Both nurse managers and ward managers perceived the ECCFs fellows positively, as enthusiastic and motivated. However, they had common negative thoughts towards the FS programme. As can be seen in the theme ‘Misfit between Policy and Practicality’ in nurse managers (5.3.3) and ‘Expectations and Reality’ in ward managers (5.4.2), both thought that FS overwhelmed RQNs and there were not enough resources and support for RQNs to complete FS. Similar perceptions and experiences were reported among RQNs involved in ECCFs and FS as they thought ECCFs were a good opportunity for them to develop, but FS was not really helping them in clinical practice.

Nurse managers and ward managers spoke about their understanding and experience of policy implementation in their health board or ward. Nurse managers perceived the government initiatives as relatively positive and understood the drive as well as the financial challenges (6.2.1). On the other hand, ward managers were experiencing difficulties and expressed their doubt and concern in relation to policy implementation.

5.10.2 Nurse Managers and Ward Managers in Japan

In Japan, both nurse managers and ward managers were very much aware of the impact of the legislative change (2.6.7) and its impact on clinical practice. Thus, the same theme emerged from the interviews, ‘Numbers and Quality of Nurses’. Additionally, they both spoke about the characteristics of RQNs who were employed around the time of the legislative change. While Scottish managers had different views, Japanese managers shared a similar understanding and expectation towards these government initiatives. The different views towards policies were highlighted between Japanese nurse managers and

ward managers. Nurse managers identified several issues, such as lack of registration system, related to clinical nursing practice as well as commenting on the policies related to nursing workforce planning (6.6.1), whereas the ward managers were more aware of the policy implementation process as some reported there was not enough support and resources (6.7.1)

Table 5-10: Themes emerged from the interviews in Scotland and Japan

	Scotland	Japan
Nurse Managers	Policy Implementation Expectations and Perceptions of ECCFs and FS Misfit between Policy and Practicality	Japanese Nursing and Policies Numbers and Quality of Nurses New Generation of Nurses
Ward Managers	Change Expectations and Reality Before Coming into Nursing Practice	Government Initiatives Numbers and Quality of Nurses New Generation of Nurses
Recently Qualified Nurses	Experience of being a Recently Qualified Nurse Contrasting Perceptions and Experiences	Transition Process

In the next sections, the themes between Scotland and Japan are compared within the same interview group and similarities and differences are presented.

5.10.3 Nurse Managers

Table 5-11 shows the themes and categories that emerged from the interviews with nurse managers in Scotland and Japan. As can be seen, both countries had three themes emerged from the interviews: one related to their perceptions of government policies and the other two from their experience and perception of policy implementation.

The perception of government policies between the two countries had some similarities and differences. Firstly, both countries' nurse managers had a shared understanding of the policy drive and goals and a favourable perception towards the government initiatives (5.3.1 and 5.7.1), in addition to concerns about the resource allocation for the policy implementation (5.3.1, 'Engagement' and 5.7.1, 'Nursing Workforce Planning Policies'). In contrast, only Scottish nurse managers perceived the current financial situation as a challenge or a good opportunity for an improvement. Although asked, no Japanese nurse manager commented about the financial status of the Japanese healthcare system.

Their experience and perception of the government initiatives also had something in common as well as differences. The common response was that there was a misfit between the expectations and the actual outcome of government initiatives. For example, in

Scotland, FS was seen and understood as good structured support for RQNs at the beginning of their career in nursing (2.6.7). However it turned out that FS involved lots of extra work for RQNs and it was not working as well as it could due to the lack of resources (6.2.2 and 6.2.3). In Japan, a similar situation was also reported. The recent legislative change in the medical care fee schedule was initially intended to increase the number of registered nurses in the clinical settings and ultimately to improve the quality of nursing care (2.7.7). However, improved quality of nursing care was identified as a concern. Also the lack of support for other staff nurses who were in charge of educating and mentoring the recently qualified nurses (5.7.2) was an issue.

A unique theme emerged from Japanese interviews, which was about RQNs in terms of their characteristics, their pre-registration courses and their clinical nursing skills (5.7.3). Japanese nurse managers reported that RQNs were not well prepared for clinical practice in terms of their psychological status and their clinical skills and knowledge. However, in Scotland one could argue that FS was a recognition of much the same view regarding clinical skills.

Table 5-11: Themes and Categories of Nurse Managers

	Themes	Categories
Scotland	Policy Implementation	Policy Goals and Approaches Engagement Implementing Initiatives into Clinical Practice
	Expectations and Perceptions of ECCFs and FS	Structured Support Motivated and Enthusiastic Staying in the Clinical Area
	Misfit between Policy and Practicality	A lot of work to do Awareness and Involvement Support and Resources Doubt about the Initiatives
Japan	Japanese Nursing and Policies	Issues in Japanese Nursing Nursing Workforce Planning Policies
	Numbers and Quality of Nurses	Impact of 7:1 Patient Nurse Ratio Doubt in the Quality of Experienced Nurses as Clinical Educators
	New Generation of Nurses	Characteristics of RQNs Theory-Practice Gap Organisational Support for RQNs

5.10.4 Ward Managers

Table 5-12 shows the themes and categories from the interviews with ward managers in Scotland and Japan. As can be seen, both countries had three themes: one based on their perceptions of government policies, one from their experience and perception of policy

implementation, and the last one was about their perceptions and issues related to recently qualified nurses.

Scottish ward managers had an understanding of government policies and their expected role in policy implementations (6.3.1). They experienced difficulties in terms of implementing government policies in their ward and experienced changes in their role. On the other hand, Japanese ward managers did not face as much change and difficulties in terms of implementing government initiatives.

The responses to government initiatives targeted/related to RQNs among ward managers were relatively similar as they both had some doubt on the effectiveness of the initiatives. In Scotland, FS was perceived as good support for RQNs to ease their transition process. However, ward managers had concerns on the effectiveness and practicality of FS and the structure of FS was not suitable for the situation of RQNs. Japanese ward managers also had some doubts on the government initiatives as they had not yet experienced the intended outcome, improved nursing care quality. Japanese ward managers were concerned about the quality and ability of other staff nurses in charge of RQNs' clinical education (5.8.2).

In both countries, ward managers commented on the change in pre-registration courses, the shift to university education, as well as the change in characteristics of Japanese RQNs. Ward managers thought that the change in the pre-registration course resulted in poorer clinical nursing skills and this was one of the reasons why the initiatives for RQNs started (5.4.3 and 5.8.3)

Table 5-12: Themes and Categories of Ward Managers

	Themes	Categories
Scotland	Change	Policy Implementation Doubt about Policy and Change
	Expectations and Reality	Support Enthusiastic and Committed ECCFs Fellows Doubt about the Practicality and Effectiveness
	Before Coming into Nursing Practice	Recruiting the 'Right Person' into Nursing Change in Pre-Registration Nursing
	Expectation towards Government Policy	
Japan	Numbers and Quality of Nurses	Impact of 7:1 Patient Nurse Ratio Experienced Nurses
	New Generation of Nurses	Characteristics of RQNs Expectation of Orientation Training System

5.10.5 Recently Qualified Nurses

As there were no similar government-driven programmes for RQNs in Japan, no similar themes emerged related to RQNs' perceptions and experiences of the government driven programmes. However, there were similar themes and categories from the experience of being a RQN.

In both countries, RQNs experienced a difficult time at the beginning of their career as a newly qualified nurse (5.5.1 and 5.9.1). For example, One Scottish RQN described her early nursing career as overwhelming and frightening whereas a Japanese RQN described her early nursing career as being very nervous and not knowing what she was doing. As time went by, RQNs in both countries developed their professional identity and responsibility by establishing a relationship with other members of staff. Even though Scottish and Japanese nurses used different terms to explain the process of establishing confidence, they both described the relationship with their colleagues. For example, one in Scotland described how lucky she was to know the member of staff before she started to work as a qualified nurse in that ward. One in Japan said that it was helpful to have feedback from other staff nurses.

Table 5-13: Themes and Categories of Recently Qualified Nurses

Themes		Categories
Scotland	Experiences of being a Recently Qualified Nurse	Appreciation of the Work Environment Transition Process Support through Transition Process
	Contrasting Perceptions and Experiences	ECCFs are a Good Opportunity and Challenging FS is boring and not helping Lack of Understanding
Japan	Transition Process	Establishing Professional Identity Expectation and Experience Gap Relationship with Other Members of Staff

5.10.6 Overall Summary

Comparison of themes and categories between Scotland and Japan provided a bigger picture of findings of these two countries. There were some similarities in terms of perceptions and experiences of government initiatives and their impact at the operational level among managers. In terms of government initiatives and their impact, nurse and ward managers understood the policy background and goals. However, they had doubts and concerns about how policy was implemented and if the policy goal had been achieved or

not. Between nurse managers and ward managers, there were some differences in their perceptions and experiences on policy implementation. Scottish and Japanese RQNs had similar experiences at the beginning of their nursing career.

Chapter 6: Results of the Questionnaires

A mixed methods approach was applied to enhance the validity of the study by using quantitative and qualitative approaches (see 3.3). The questionnaires were applied in this study to answer research question 2 (to what extent are registered nurses in clinical practice aware of these policies?) and to investigate the responses to these policies at the local level with hospital based registered nurses (research question 3). The results of the questionnaires were used to supplement the findings of the qualitative approaches and also to gain a general view of the nursing practice environment in each country.

The results of Part 1: Scotland and Part 2: Japan are presented separately. The comparison of the results between Scotland and Japan are presented in the last part of this chapter.

Results from each section are presented in the following order: firstly, response rate and demographic data are presented; secondly, RNs' awareness of government policies related to their clinical practice. Next, RNs' perceived changes in the workplace over the last 12 months (the results from adapted POWCS) are described, and then. RNs' general views of their nursing practice environment, which was measured by the adapted PES-NWI, are presented.

In this chapter, the numbers are all written in numerals in order to read the chapter easily.

6.1 Part 1: Scotland

6.1.1 Response Rate and Demographic Data

In Scotland, 318 questionnaires were distributed. A total of 120 questionnaires were returned. The response rate was 37.7%. One questionnaire was excluded from the data analysis because it was returned as blank. A total of 119 questionnaires were included for data analysis. Table 6-1 shows the profile of the questionnaire respondents. Scottish respondents were primarily female (83.5%), had worked in their current position for less than 5 years (44.3%), had been registered for 2-5 years (31.3%) and had a degree (59.8%).

There were 13 recently qualified nurses (RQNs) registered for 24 months or less and 102 registered nurses registered more than 24 months.

Table 6-1: Profile of Questionnaire Respondents

Profile		Scotland
Response Rate		
	Distributed	318
	Returned	120
	Response rate	37.7%
	Numbers included for calculation	119
Sex		
	Female	96 (83.5%)
	Male	19 (16.5%)
	Missing	4
	Total	119
Length of Working at Current Position		
	≤12months	16 (13.9%)
	13months-5years	51 (44.3%)
	6-10years	31 (27.0%)
	11-15 years	11 (9.6%)
	16-20years	3 (2.6%)
	More than 20 years	3 (2.6%)
	Missing	4
	Total	119
Length of Registration		
	≤24months	13 (11.3%)
	2-5years	36 (31.3%)
	6-10 years	33 (28.7%)
	11-15 years	12 (10.4%)
	16-20 years	9 (7.8%)
	More than 21 years	12 (10.4%)
	Missing	4
	Total	119
Educational Background		
	Pre-registration Diploma	11 (9.8%)
	Post-registration Diploma	17 (15.2%)
	Degree	67 (59.8%)
	Master	4 (3.6%)
	Other	13 (11.6%)
	Missing	7
	Total	119

6.1.2 Awareness of Policies Related to RNs' Clinical Practice

Only nurses registered (n=102) for more than 24 months answered this part of questionnaire (see Appendix XVI, Q21-Q23). RNs were asked about their awareness of Scottish Government policy relating to their area of clinical practice in health policy and nursing workforce planning and the degree of the impact on clinical practice.

As can be seen in Table 6-2 there were 3 questions concerning RNs' awareness of the policies, and the degree of perceived impact on their clinical practice. Most RNs were aware of the Scottish Government policies related to health policy and nursing workforce. They were also aware of the impact of these policies on their clinical practice, even though the perceived degree of impact varied among RNs. In particular, almost one third of RNs were very much aware of government health policies, and nearly 40% of RNs answered that they thought the Scottish Government policies had a great impact on their clinical practice.

Table 6-2: Awareness of the Policies and their Impact on Clinical Practice among Scottish RNs

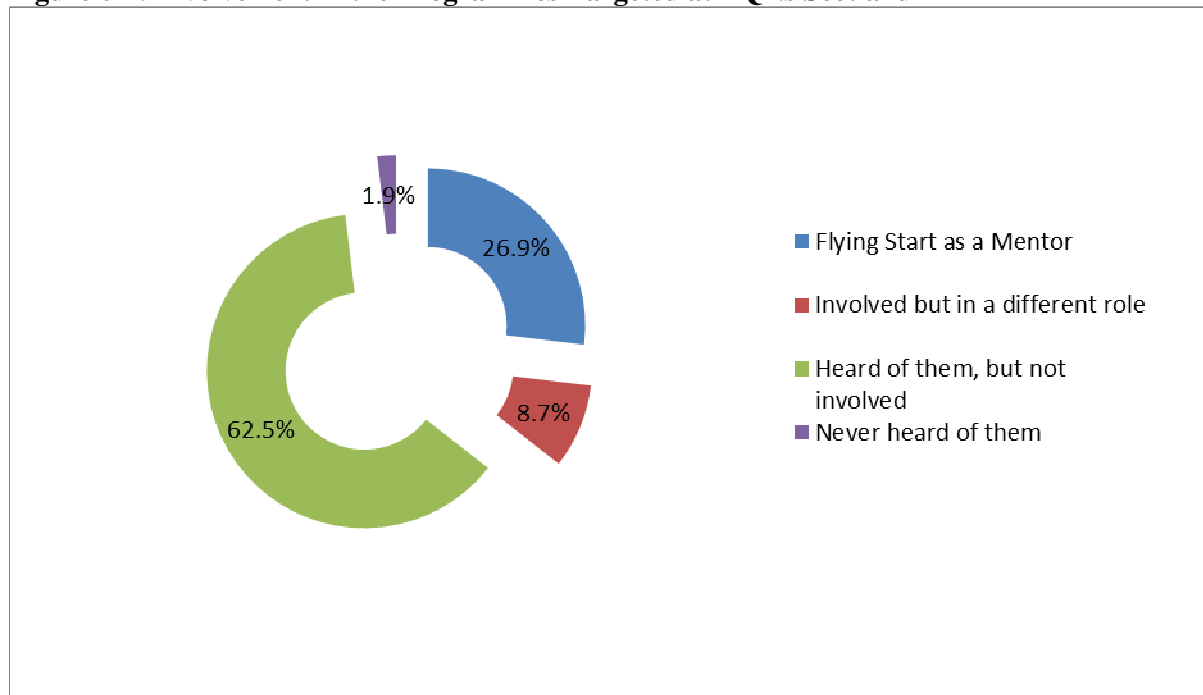
Number of RNs who were registered for more than 24 months n=102[§]		RNs (%)
Awareness of government health policies related to clinical practice	Not at all	3 (3.0%)
	To some degree	69 (68.3%)
	Very much	29 (28.7%)
	Missing Data	1
Awareness of government policies related to nursing workforce planning	Not at all	18 (17.8%)
	To some degree	74 (73.3%)
	Very much	9 (8.9%)
	Missing Data	1
The degree of the impact of government policies on clinical practice	Not at all	3 (3.0%)
	To some degree	57 (57.6%)
	Very much	39 (39.4%)
	Missing Data	3

[§]: All missing data were excluded from analysis on statistical advice. *: p<0.01 **: p<0.001

Involvement with the Programme Targeted at RQNs

Figure 6-1 shows the involvement of RNs who were registered for more than 24 months in the programmes targeted at RQNs. As discussed before (see 2.6.7) there are 2 programmes targeted at RQNs in Scotland, 'Flying Start' and 'Early Clinical Career Fellowships'. The result showed that 62.5% of RNs had heard of the programmes, but were not involved. One third of the RNs were involved in these programmes as a mentor for 'Flying Start' (26.9%), or other role (8.7%). Only 1.9% of RNs had never heard of these programmes.

Figure 6-1: Involvement in the Programmes Targeted at RQNs Scotland



6.1.3 Perceived Change in the Workplace over the Last 12 Months

Only nurses registered for more than 24 months answered this part of questionnaire (see Appendix XVI, Q5-Q20). RNs were asked to respond (n=102) on their perception of change in their workplace over the last 12 months with 16 questions based on the adapted POWCS. The results of the POWCS are presented under each subscale: Pressure, Strength, Concerns.

Pressure

Table 6-3 shows RNs' registered for more than 24 months perceived changes in their workplace with three items in the 'Pressure' subscale. Three items in 'Pressure' measured the negative aspects of the workplace which may show the negative impact on RNs' wellbeing, such as job satisfaction and morale. More than half of all RNs reported that their level of stress, workload, and their responsibilities had increased. Significantly more respondents answered 'increased' for the change in the level of stress ($\chi^2=22.04$, $p<0.001$), workload ($\chi^2=36.94$, $p<0.001$) and responsibility ($\chi^2=38.37$, $p<0.001$), compared to 'decrease'.

Table 6-3: Scottish RNs' Pressure (POWCS) in the workplace over the last 12 months

Pressure		RNs n=102 [§] (%)	χ^2	df	p<0.01
The level of stress I feel has	Increased	54 (54.0%)	22.04	1	p<0.001**
	Stayed about the same	31 (31.0%)			
	Decreased	15 (15.0%)			
	Missing	2			
My workload has	Increased	57 (57.0%)	36.94	1	p<0.001**
	Stayed about the same	35 (35.0%)			
	Decreased	8 (8.0%)			
	Missing	2			
My responsibilities have	Increased	65 (64.5%)	38.37	1	p<0.001**
	Stayed about the same	25 (24.8%)			
	Decreased	11 (10.9%)			
	Missing	1			

[§]:All missing data were excluded from analysis on statistical advice.*: p<0.01 **: p<0.001

Strength

Table 6-4 shows RNs' (registered for more than 24 months) perceived changes in their workplace regarding 7 items in the 'Strength' subscale. The items in the 'Strength' are a reflection of aspects which enhance the feeling of a positive work environment. There are 3 items that overlap between 'Strength' and 'Concerns', and these 3 items are presented in 'Strength' subscale and excluded from Concern' in order to avoid repetition. Significantly more respondents answered 'decreased' for the change in morale among their colleagues ($\chi^2=19.51$, $p<0.001$). Additionally, nearly half of RNs reported that their feelings of being a valued employee and their job satisfaction had 'decreased'. Despite the fact that RNs reported more 'Pressure' related to their work and the negative impacts such as decreased job satisfaction, more than 30% of RNs felt that the quality of care they were providing had improved.

Table 6-4: Scottish RNs' Strength (POWCS) in the workplace over the last 12 months

Strength		RNs n=102 [§] (%)	χ^2	df	p<0.01
The quality of care I am able to give has			13.52	1	p<0.001**
	Increased	38 (38.0%)			
	Stayed about the same	50 (50.0%)			
	Decreased	12 (12.0%)			
	Missing	2			
The sense of personal achievement I get from work has			1.47	1	p=0.225
	Increased	39 (39.0%)			
	Stayed about the same	32 (32.0%)			
	Decreased	29 (29.0%)			
	Missing	2			
My job satisfaction has			2.44	1	p=0.118
	Increased	28 (27.7%)			
	Stayed about the same	32 (31.7%)			
	Decreased	41 (40.6%)			
	Missing	1			
The amount of time I have to talk to patients has			5.77	1	p=0.016
	Increased	12 (11.9%)			
	Stayed about the same	62 (61.4%)			
	Decreased	27 (26.7%)			
	Missing	1			
The amount of time I have for direct patient care			3.27	1	p=0.070
	Increased	16 (15.8%)			
	Stayed about the same	57 (56.4%)			
	Decreased	28 (27.7%)			
	Missing	1			
My satisfaction with my overall working conditions has			1.37	1	p=0.241
	Increased	25 (24.8%)			
	Stayed about the same	42 (41.6%)			
	Decreased	34 (33.7%)			
	Missing	1			
My feelings of being a valued employee have			4.95	1	p=0.026
	Increased	27 (26.7%)			
	Stayed about the same	28 (27.7%)			
	Decreased	46 (45.5%)			
	Missing	1			
The morale of my colleagues has			19.51	1	p<0.001**
	Increased	18 (18.0%)			
	Stayed about the same	26 (26.0%)			
	Decreased	56 (56.0%)			
	Missing	2			

[§]:All missing data were excluded from analysis on statistical advice. *: p<0.01 **: p<0.001

Concerns

Table 6-5 shows RNs' (registered for more than 24 months) perceived changes in their workplace over the last 12 months regarding 5 items in the 'Concerns' subscale. The items in 'Concerns' are a reflection of aspects that enhance the feeling of a negative work environment. As well as job satisfaction, significantly more RNs felt their pay satisfaction had 'decreased' compared to those who answered 'increased' ($\chi^2=19.69$, $p<0.001$). On the other hand, the feedback concerning the available resources to provide patient care was a significantly bigger proportion of RNs compared to the RNs who felt it had 'decreased' ($\chi^2=8.00$, $p=0.005$).

Table 6-5: Scottish RNs' Concerns (POWCS) in the workplace over the last 12 months

Concerns		RNs n=102 [§] (%)	χ^2	df	p<0.01
The resources I have to provide care have			8.00	1	p=0.005*
	Increased	35 (34.7%)			
	Stayed about the same	51 (50.5%)			
	Decreased	15 (14.9%)			
	Missing	1			
The quality of communication with managers has			4.57	1	p=0.033
	Increased	20 (20.0%)			
	Stayed about the same	44 (44.0%)			
	Decreased	36 (36.0%)			
	Missing	2			
My feeling of job security has			4.57	1	p=0.03
	Increased	12 (11.9%)			
	Stayed about the same	64 (63.4%)			
	Decreased	25 (24.8%)			
	Missing	1			
My satisfaction with my pay has			19.69	1	p<0.001**
	Increased	10 (10.0%)			
	Stayed about the same	48 (48.0%)			
	Decreased	42 (42.0%)			
	Missing	2			
Staffing levels have			3.27	1	p=0.071
	Increased	23 (23.0%)			
	Stayed about the same	40 (40.0%)			
	Decreased	37 (37.0%)			
	Missing	2			

[§]:All missing data were excluded from analysis on statistical advice. *: p<0.01 **: p<0.001

Summary of Key Results

Scottish RNs reported increased stress, workload and responsibilities over the last 12 months that were considered a negative impact on the workplace. Additionally, the negative aspects of their working environment were also reported, such as decreased morale, job dissatisfaction, and dissatisfaction with pay. Despite negative impact on the workplace and negative aspects of the work environment, RNs believed that their quality of care had improved and the resources they could use to provide nursing care had increased.

6.1.4 General View of Scottish RNs' Nursing Practice Environment

All RNs were asked about their nursing practice environment with 30 Likert-type questions (1: Strongly Disagree - 4: Strongly Agree) using the adapted PES-NWI. A total of 119 RNs answered these questions (Q50-Q79). The PES-NWI has 30 items to measure the hospital nursing practice environment in 5 subscales (Nurse Participation in Hospital Affairs; Nursing Foundations for Quality of Care; Nurse Manager Ability, Leadership, and Support of Nurses; Staffing and Resource Adequacy; Collegial Nurse-Physician Relations). The results are presented by each scale, and the mean scores of each scale are presented at the end.

Nursing Participation in Hospital Affairs

All RNs were asked to comment on nurses' involvement in hospital and nursing department affairs such as internal governance, policy decisions and committees. There were 9 items in 'Nursing Participating in Hospital Affairs'. As can be seen in Table 6-6, there were significantly more Scottish RNs who agreed that the Nursing Lead in their division had equal authority to other Divisional leads ($\chi^2=15.06$, $p<0.001$), and that their ward managers consulted on daily problems and procedures compared to RNs who disagreed ($\chi^2=30.27$, $p<0.001$). Although in the previous section (see 6.1.3), 36% of RNs perceived a change in the quality of communication with managers, 75% of RNs agreed that they had opportunities to discuss with managers about daily problems and procedures.

Table 6-6: PES-NWI 'Nursing Participation in Hospital Affairs' Scotland

Number of Scottish RNs =119 [§]	Agree (%)	Disagree (%)	Missing data	χ^2	df	p-value
Our hospital has career development opportunities	71 (60.7%)	46 (39.3%)	2	5.34	1	p=0.021
Our hospital has opportunities for staff nurses to participate in policy decisions	50 (43.5%)	65 (56.5%)	4	1.96	1	p=0.162
Our Division's Nursing Lead is highly visible and accessible to staff	63 (54.3%)	53 (45.7%)	3	0.86	1	p=0.353
The Nursing Lead in my Division is equal in power and authority to other Divisional leads	70 (69.3%)	31 (30.7%)	18	15.06	1	p<0.001**
We have opportunities for advancement	52 (45.6%)	62 (54.4%)	5	0.88	1	p=0.349
Our organisation listens and responds to employee concerns	47 (41.6%)	66 (58.4%)	6	3.20	1	p=0.074
Staff nurses are involved in the internal governance of the hospital (e.g. practice and policy committees)	53 (48.6%)	56 (48.6%)	10	0.83	1	p=0.774
Staff nurses have the opportunity to serve on hospital and nursing committees	61 (57.0%)	46 (43.0%)	12	2.10	1	p=0.147
Ward managers/senior charge nurses/ ward sisters consult with staff on daily problems and procedures.	87 (75.7%)	28 (24.3%)	4	30.27	1	p<0.001**

[§]:All missing data were excluded from analysis on statistical advice. *: p<0.01 **: p<0.001

Nursing Foundation for Quality of Care

‘Nursing Foundation for Quality Care’ measures staff development opportunity and the quality of management. All RNs were asked to express their opinion on 9 items. As can be seen in Table 6-7 the majority of RNs agreed with all 9 items even though the percentage of agreement varies from 69.5% to 97.4%. This means that most Scottish RNs in this study held favourable opinions towards their staff development opportunities and the quality of management.

Table 6-7: PES-NWI ‘Nursing Foundation for Quality Care’ Scotland

Number of Scottish RNs=119 [§]	Agree (%)	Disagree (%)	Missing data	χ^2	d f	p<0.01
Our hospital has active in-service/ continuing professional education programmes for nurses	87 (74.4%)	30 (25.6%)	2	27.77	1	p<0.001**
High standards of nursing care are expected by the organisation	106 (91.4%)	10 (8.6%)	1	79.45	1	p<0.001**
We have a clear philosophy of nursing that pervades the patient care environment	91 (79.8%)	23 (20.2%)	5	40.56	1	p<0.001**
We are working with nurses who are clinically competent	93 (80.9%)	22 (19.1%)	4	43.85	1	p<0.001**
We have an active quality-assurance programme	76 (68.5%)	35 (31.5%)	8	15.14	1	p<0.001**
We have a mentorship programme for recently qualified registered nurses	111 (97.4%)	3 (2.6%)	5	102.32	1	p<0.001**
Nursing care is based on a nursing rather than a medical model	89 (78.1%)	25 (24.9%)	5	35.93	1	p<0.001**
Our nursing care plans for all patients are up-to-dated and shared	94 (82.5%)	20 (17.5%)	5	48.04	1	p<0.001**
Patient allocation fosters continuity of care (i.e., the same nurse cares for the patient from one day to the next)	86 (76.1%)	27 (23.9%)	6	30.81	1	p<0.001**

[§]:All missing data were excluded from analysis on statistical advice. *: p<0.01 **: p<0.001

Nurse Manager Ability, Leadership and Support

RNs were asked to comment on their nurse manager's ability, leadership, and support of RNs. As can be seen Table 6-8 there are 5 items in 'Nurse Manager Ability, Leadership and Support of Nurses'. More than 80% of RNs agreed that they had a good and supportive ward manager. Regarding the other 3 factors, opinion was not conclusive. In particular, they agreed that they had a good and supportive ward manager who backed up RNs in their decision making, but half of RNs disagreed that they had supportive managerial staff.

Table 6-8: PES-NWI 'Nurse Manager Ability, Leadership and Support of Nurses' Scotland

Number of Scottish RNs=119 §	Agree (%)	Disagree (%)	Missing data	χ^2	df	p<0.01
Our hospital has managerial staff that are supportive of nurses	58 (50.4%)	57 (49.6%)	4	0.01	1	p=0.926
Managers use mistakes as learning opportunities, not for criticising	71 (60.7%)	46 (39.3%)	2	5.34	1	p=0.021
We have a ward manager/senior charge nurse/ ward sister who is a good manager and leader	101 (85.6%)	17 (14.4%)	1	59.80	1	p<0.001**
We receive praise and recognition for a job well done	49 (41.9%)	68 (58.1%)	2	3.09	1	p=0.79
We have a ward manager/senior charge nurse/ ward sister who backs up the nursing staff in decision making, even if the conflict is with a physician	95 (83.3%)	19 (16.7%)	5	50.67	1	p<0.001**

§:All missing data were excluded from analysis on statistical advice. *: p<0.01 **: p<0.001

Staffing and Resource Adequacy

‘Staffing and Resource Adequacy’ had 4 items to examine the nursing practice environment related to staffing and resources. As can be seen in Table 6-9 there are 2 items that more than 70% of RNs agreed with: More than 80% of RNs agreed that their hospital prioritised RNs’ time with patients, and more than 70% of RNs reported that they had enough RNs to provide the quality patient care.

Table 6-9: PES-NWI ‘Staffing and Resource Adequacy’ Scotland

Number of Scottish RNs=119 §	Agree (%)	Disagree (%)	Missing data	χ^2	df	p<0.01
Our hospital believes that it is important for me to spend more time with my patients	94 (81.0%)	22 (19.0%)	3	44.69	1	p<0.001**
We have enough time and opportunity to discuss patient care problems with other nurses	73 (61.9%)	45 (38.1%)	1	6.64	1	p=0.01
Our ward has enough registered nurses on staff to provide quality patient care	82 (70.7%)	34 (29.3%)	3	19.86	1	p<0.001**
Our hospital has enough staff to get the work done	50 (43.5%)	65 (56.5%)	4	1.96	1	p=0.162

§:All missing data were excluded from analysis on statistical advice. *: p<0.01 **: p<0.001

Similar results were shown in the previous subscale ('Nursing Foundation for Quality of Care'), that hospitals expect RNs to provide a high standard of care (more than 90% of RNs agreed that their hospital expects a high standard of nursing care).

On the other hand, it was difficult to conclude from the results whether the hospital had enough staff to get the work done or not. A similar result can be found in the previous section (see 6.1.3), where more than 30% of RNs experienced a decrease in staffing levels.

Collegial Nurse-Physician Relations

All RNs were asked to comment on their relationship with physicians. As can be seen in Table 6-10 there are 3 statements, and RNs were asked to indicate if they agreed with the statement or not. More than 70% of RNs agreed that they had good working relationships and good teamwork between nurses and physicians.

Table 6-10: PES-NWI ‘Collegial Nurse-Physician Relations’ Scotland

Number of Scottish RNs=119 §	Agree (%)	Disagree (%)	Missing Data	χ^2	df	p<0.01
Doctors and nurses have good working relationships	87 (75.7%)	28 (24.3%)	4	30.27	1	p<0.001 **
There is much teamwork between nurses and doctors	80 (70.2%)	34 (29.8%)	5	18.56	1	p<0.001 **
We have collaboration between nurses and physicians	74 (65.5%)	39 (34.5%)	6	10.84	1	p=0.001 *

§:All missing data were excluded from analysis on statistical advice.*: p<0.01 **: p<0.001

General View of Scottish RNs' Nursing Practice Environment measured by PES-NWI

As mentioned before (4.4.6), RNs were asked to rate their level of agreement (1: Strongly Disagree-4: Strongly Agree) on 30 items. The average score for each subscale (range from 1-4), and the total average score (range from 1-4) for the adapted PES-NWI are shown in Table 6-11. As noted before (see 4.4.10), values on the average score for each subscale above 2.5 were considered as 'favourable' and the number of 'favourable' subscales indicates the 3 classifications of nursing practice environment: 'favourable' (4-5), 'mixed' (2-3) and 'unfavourable' (0-1).

The highest average score among the 5 subscales was 3.06 for 'Nursing Foundation for Quality of Care' and the lowest average score was 2.51 for 'Nursing Participation in Hospital Affairs'. The overall average score of each subscale for Scotland was above 2.5. Thus the working environment for RNs in Scotland was categorised as 'favourable'.

Table 6-11: The Average Score of Each Subscale (PES-NWI) Scotland

Number of Scottish RNs=119 [§]	N	Missing data	Minimum	Maximum	Mean	SD
Nursing Participation in Hospital Affairs	90	29	1.22	3.67	2.51	0.53
Nursing Foundations for Quality of Care	104	15	1.33	3.89	3.06	0.48
Nurse Manager Ability, Leadership, and Support of Nurses	110	9	1.00	4.00	2.68	0.64
Staffing and Resource Adequacy	111	8	1.00	4.00	2.72	0.59
Collegial Nurse-Physician Relations	110	9	1.33	4.00	2.77	0.61
Total Average Score	81	38	1.57	3.80	2.74	0.44

[§]:All missing data were excluded from analysis on statistical advice

Summary of Key Results

Most Scottish RNs in this study agreed that they had good and supportive ward managers who backed up RNs in difficult situations and consulted on daily problems with RNs. In addition, they had good working relationships and teamwork with physicians. RNs perceived that hospitals had expectations for RNs to provide high standards of care and spend more time with patients. The mean score of 5 subscales was above 2.5 which classified the Scottish nursing practice environment as 'favourable'.

6.1.5 RNs' Intention to Leave Nursing or Current Job

All RNs were asked about their intention to leave their profession and their current job (Q80-Q81). A total of 119 RNs answered these questions. As can be seen in the Figure 6-2 most (80.3%) RNs had thought about leaving their current job occasionally in the last 12 months and 1 in 10 Scottish RNs in this study had thought about leaving their job everyday in the last 12 months. Regarding their intention to leave the nursing profession, a smaller percentage (59.0%) of RNs had thought about it at least occasionally in the last 12 months. It has to be noted that more than double the number of RNs never thought about leaving nursing compared to the number who thought about leaving their current job.

Figure 6-2: Intention to Leave Current Position among Scottish Study RNs

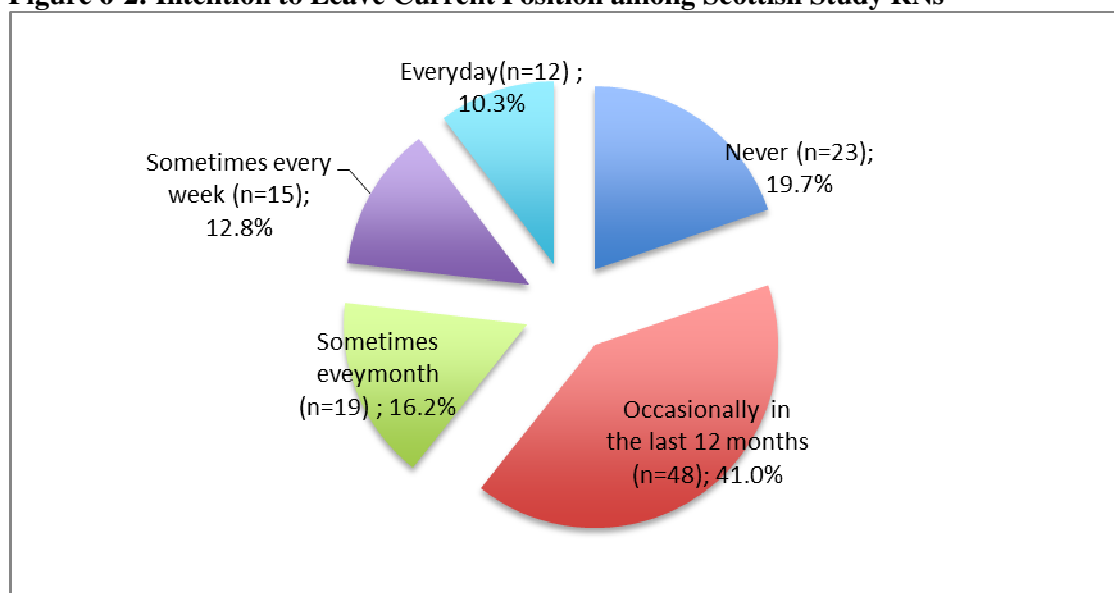
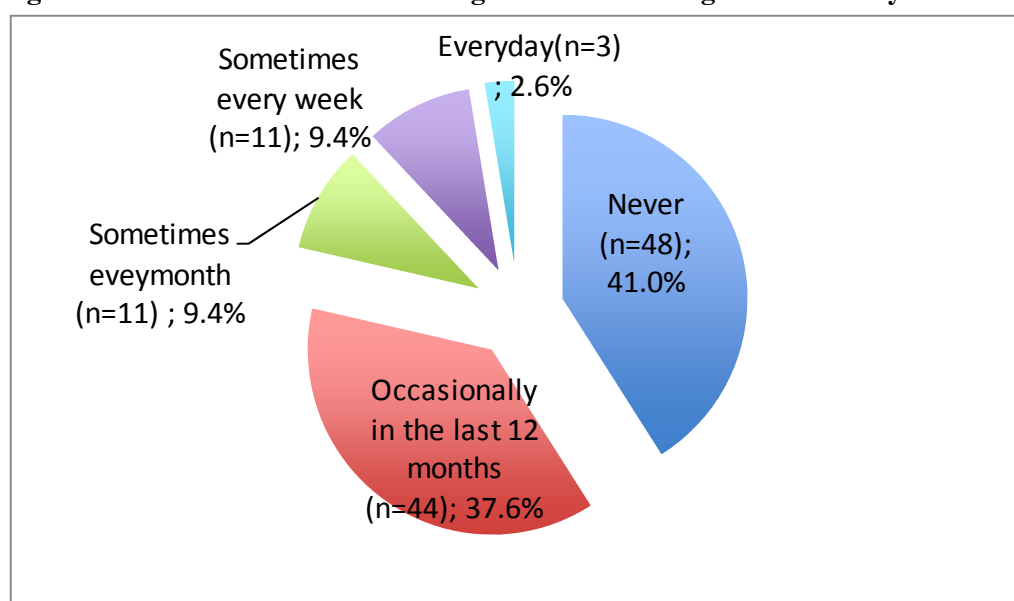


Figure 6-3: Intention to Leave Nursing Profession among Scottish Study RNs



6.1.6 Experiences of Recently Qualified Nurses in Scotland (RQN)

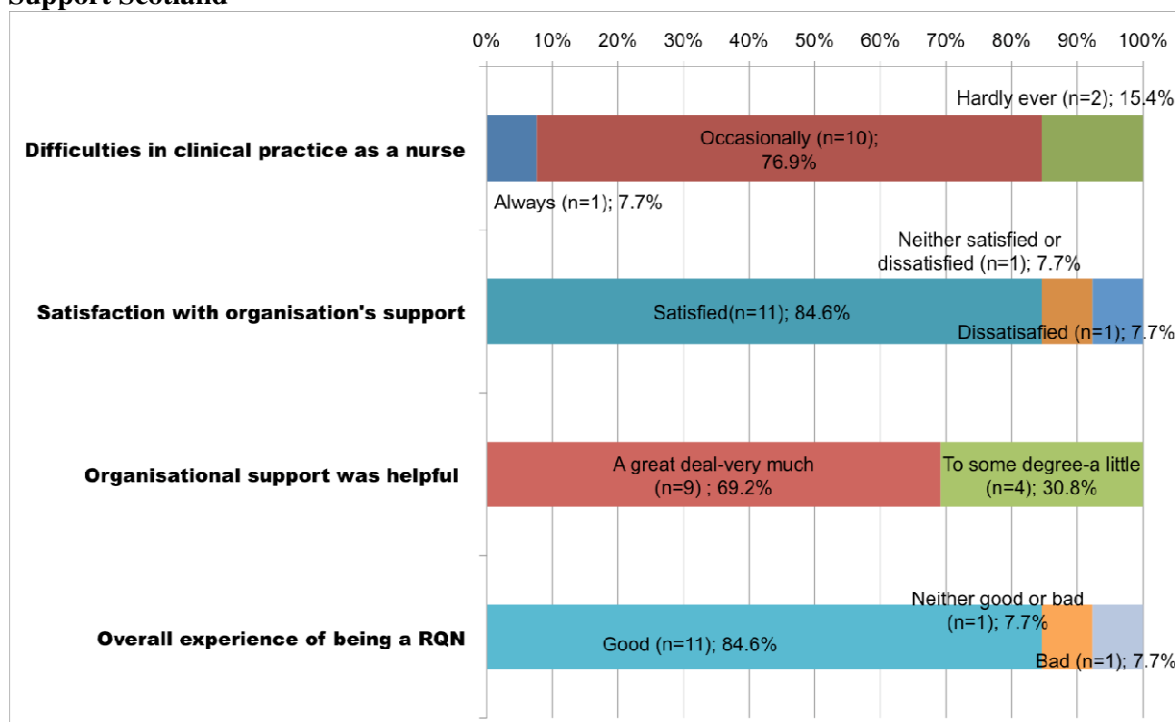
RQNs were asked about their perceived experiences of being a RQN and their experience of being involved in 'Flying Start' and 'Early Clinical Career Fellowships' with 25 questions (Q25-Q49). A total of 13 RNs who were registered for 24 months or less answered these 25 questions. Due to the small sample size, no statistical test was applied on the advice from a statistician.

In Relation to Experiences as a Recently Qualified Nurse

Figure 6-4 shows the perception of experience as a RQN and organizational support during the early period of their nursing career. Most of the RQNs (n=10, 76.9%) reported that they had 'occasionally' had difficulties in familiarising themselves in clinical practice, but mostly they (n=11, 84.6%) were satisfied with the organization's support and thought it was helpful to a great deal. Overall, they reported their experience of being a recently qualified nurse as 'good' (n=11, 84.6%).

More than 80% (n=11) of RQNs reported that a lack of knowledge and skills made familiarising themselves into clinical practice difficult to a certain degree, as well as their own negative feelings towards nursing and doubts about their abilities.

Figure 6-4: The Perceptions of Experience as a Recently Qualified Nurse and Organizational Support Scotland

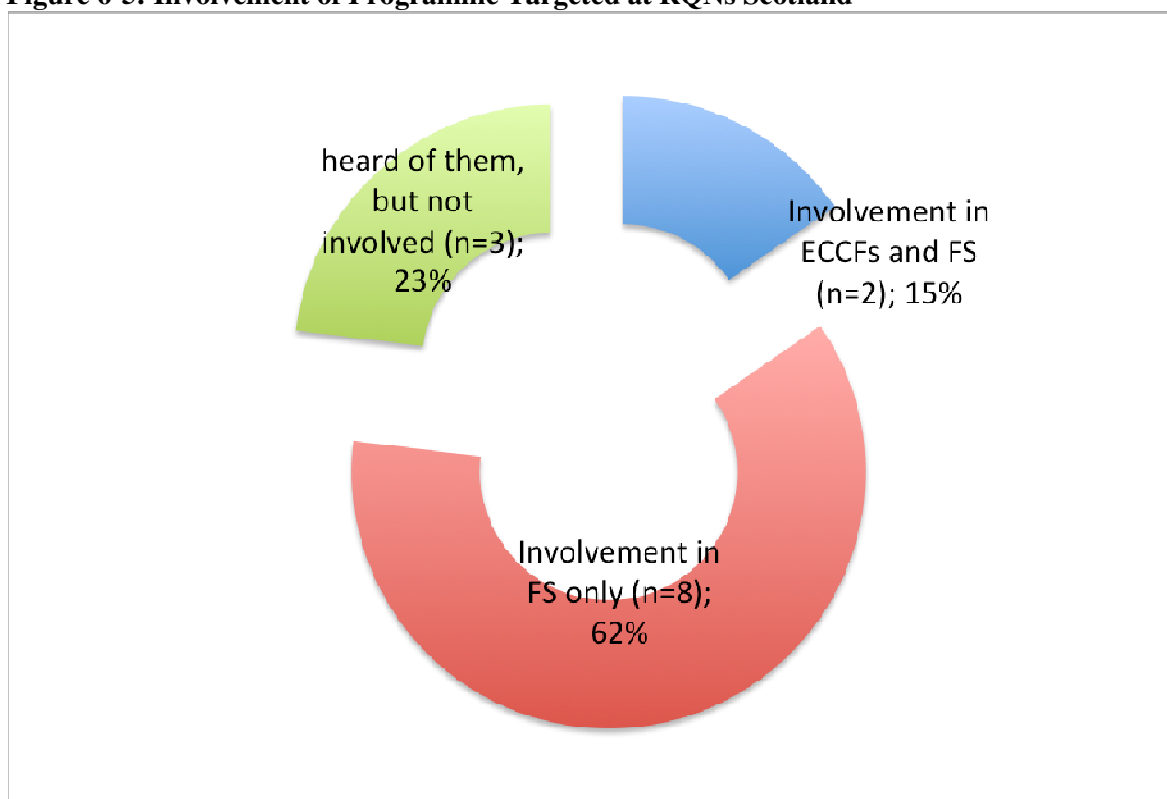


Involvement in 'Flying Start' (FS) or 'Early Clinical Career Fellowships' (ECCFs)

Figure 6-5 shows the involvement of RQNs in ECCFs or FS. All of the respondents were aware of the programmes targeted at RQNs. Two out of 13 RQNs had been involved in ECCFs and FS, and an additional 8 were in FS only.

RNs involved in ECCFs agreed that ECCFs were helpful in terms of developing clinical skills and their careers, but more than half of respondents reported that FS was not helpful at all in terms of familiarising themselves into clinical practice.

Figure 6-5: Involvement of Programme Targeted at RQNs Scotland



6.2 Part 2: Japan

6.2.1 Response Rate and Demographic Data

In Japan, the questionnaire was distributed to 180 registered nurses and 83 of them returned the questionnaire. The response rate was 46.11%. The Japanese respondents were predominantly female (80.0%), and had worked in their current position for less than 5 years (82.5%), had been registered for 6-10 years (38.8%), and 41.2% had a degree.

Table 6-12: Profile of Questionnaire Respondents

Profile		Japan
Response Rate		
	Distributed	180
	Returned	83
	Response rate	46.1%
	Numbers included for calculation	83
Sex		
	Female	64 (80.0%)
	Male	16 (20.0%)
	Missing	3
	Total	83
Length of Working at Current Position		
	≤12months	10 (12.5%)
	13months-5years	56 (70.0%)
	6-10years	10 (12.5%)
	11-15 years	1 (1.3%)
	16-20years	3 (3.8%)
	More than 20 years	0 (0%)
	Missing	3
	Total	83
Length of Registration		
	≤24months	4 (5.0%)
	2-5years	28 (35.0%)
	6-10 years	31 (38.8%)
	11-15 years	9 (11.3%)
	16-20 years	5 (6.3%)
	More than 21 years	3 (3.8%)
	Missing	3
	Total	83
Educational Background		
	Nursing School Diploma	28 (35.0%)
	Junior Degree Diploma	16 (20.0%)
	Degree	33 (41.2%)
	Master	3 (3.8%)
	Other	0 (0%)
	Missing	3
	Total	83

6.2.2 Awareness of Policies Related to RNs' Clinical Practice

Only nurses registered (n=76) for more than 24 months answered this part of questionnaire (see Appendix XXV and Appendix XXXVI, Q21-Q23). RNs were asked about their awareness of the Japanese government policies related to their area of clinical practice in health policy, nursing workforce planning and perceived impacts on their clinical practice.

As can be seen in Table 6-12 there were 3 questions that asked RNs' awareness of the policies, and the degree of perceived impact on their clinical practice. More than half of Japanese RNs were aware of the Japanese government policies related to health policy and nursing workforce planning. Moreover, the impact of these policies on their clinical practice was perceived to some degree. However, more than one third of RNs (37.7%) were not aware of Japanese government policies related to nursing workforce planning and more than one quarter of RNs were not aware of Japanese government health policies at all.

Table 6-13: Awareness of the Policies and their Impact on Clinical Practice among Japanese RNs

Number of Japanese RNs who were registered for more than 24 months (n=76) [§]		RNs (%)
Awareness of government health policies related to clinical practice		
	Not at all	19 (27.5%)
	To some degree	48 (69.6%)
	Very much	2 (2.9%)
	Missing data	7
Awareness of government policies related to nursing workforce planning		
	Not at all	26 (37.7%)
	To some degree	41 (59.4%)
	Very much	2 (2.9%)
	Missing data	7
The degree of the impact of government policies on clinical practice		
	Not at all	13 (18.8%)
	To some degree	48 (69.6%)
	Very much	8 (11.6%)
	Missing data	7

[§]:All missing data were excluded from analysis on statistical advice.

6.2.3 Perceived Change in the Workplace over the Last 12 Months

Only nurses registered (n=76) for more than 24 months answered this part of questionnaire (see Appendix XXV and Appendix XXXVI, Q5-Q20). RNs were asked about their perception of change in their workplace over the last 12 months through 16 questions from the adapted POWCS. The results of POWCS are presented as each subscale: 'Pressure', 'Strength', 'Concerns'.

Pressure

The following table (Table 6-13) shows the results of the perceived change in 'Pressure'. The items in 'Pressure' measure the aspects of the workplace which may have a negative impact on RNs' wellbeing, such as job satisfaction and morale when they increase. More than half of the respondents answered 'increased' for a change in the level of stress (56.3%) ($\chi^2=12.52$, $p<0.001$) and workload (53.6%) ($\chi^2=20.45$, $p<0.001$), compared to the ones who answered 'decreased'. A greater number of Japanese RNs also reported that their responsibility had increased rather than decreased, but this was not statistically significant.

Table 6-14: Japanese RNs-Pressure (POWCS) in the Workplace over the Last 12 Months

Pressure		RNs n=76 [§] (%)	χ^2	df	p<0.01
The level of stress I feel has			12.52	1	p<0.001**
	Increased	40 (56.3%)			
	Stayed about the same	17(23.9%)			
	Decreased	14 (19.7%)			
	Missing	5			
My workload has			20.45	1	p<0.001**
	Increased	37(53.6%)			
	Stayed about the same	25 (36.2%)			
	Decreased	7 (10.1%)			
	Missing	7			
My responsibilities have			4.12	1	p=0.042
	Increased	27 (38.0%)			
	Stayed about the same	30 (42.3%)			
	Decreased	14 (19.7%)			
	Missing	5			

[§]:All missing data were excluded from analysis on statistical advice.*: p<0.01 **: p<0.001

Strength

Table 6-14 shows the RNs' perceived changes in their workplace regarding 7 items in the 'Strength' subscale. The items in 'Strength' are a reflection of aspects which enhance the feeling of a positive work environment. RNs were asked to rate whether it had increased or not. Nearly 50% of RNs reported that their satisfaction with their work condition had 'decreased' ($\chi^2=13.89$, $p<0.001$). Despite the increased 'Pressure' and dissatisfaction with their work conditions, nearly half of RNs felt their quality of care had 'increased', which is a significantly bigger proportion of RNs compared to the RNs who felt it had decreased ($\chi^2=12.11$, $df=1$, $p<0.001$).

Table 6-15: Japanese RNs-POWCS (Strength) Perceived Change in the Workplace over the Last 12 Months

Strength		RNs n=76 [§] (%)	χ^2	df	p<0.01
The quality of care I am able to give has			12.11	1	p=0.001*
	Increased	31 (44.3%)			
	Stayed about the same	30 (42.9%)			
	Decreased	9 (12.9%)			
	Missing	6			
The sense of personal achievement I get from work has			1.39	1	p=0.238
	Increased	19 (26.8%)			
	Stayed about the same	25 (35.2%)			
	Decreased	27 (38.0%)			
	Missing	5			
My job satisfaction has			1.45	1	p=0.228
	Increased	18 (25.4%)			
	Stayed about the same	27 (38.0%)			
	Decreased	26 (36.6%)			
	Missing	5			
The amount of time I have to talk to patients has			6.82	1	p=0.009*
	Increased	24 (33.8%)			
	Stayed about the same	38 (53.5%)			
	Decreased	9 (12.7%)			
	Missing	5			
The amount of time I have for direct patient care			1.88	1	p=0.170
	Increased	21 (30.0%)			
	Stayed about the same	36 (51.4%)			
	Decreased	13 (18.6%)			
	Missing	6			
My satisfaction with my overall working conditions has			13.89	1	p<0.001**
	Increased	10 (14.1%)			
	Stayed about the same	26 (36.6%)			
	Decreased	35 (49.3%)			
	Missing	5			
My feelings of being a valued employee have			1.40	1	p=0.237
	Increased	21 (29.6%)			
	Stayed about the same	36 (50.7%)			
	Decreased	14 (19.7%)			
	Missing	5			
The morale of my colleagues has			2.19	1	p=0.139
	Increased	14 (20.0%)			
	Stayed about the same	33 (47.1%)			
	Decreased	23 (32.9%)			
	Missing	6			

[§]:All missing data were excluded from analysis on statistical advice.*: p<0.01 **: p<0.001

Concerns

Table 6- 15 shows RNs' perceived changes in their workplace over the last 12 months regarding 5 items in the 'Concerns' subscale. The items in 'Concerns' are a reflection of aspects which enhance the feeling of a negative work environment. There are 3 items that overlap between 'Strength' and 'Concerns', and these 3 items are excluded from the 'Concerns' subscale as they were reported in Table 6-14. Significantly more Japanese RNs felt that staffing levels had decreased compared to the ones who answered 'increased' ($\chi^2=14.24$, $p<0.001$). More than half of Japanese RNs felt their satisfaction with pay had decreased and the proportion of RNs who felt it had 'decreased' was significantly larger than the ones who felt it had increased ($\chi^2=39.34$, $p<0.001$). Despite the dissatisfaction with their work conditions, nearly half of RNs felt the available resources to provide patient care had 'increased', which is a significantly bigger proportion of RNs compared to the RNs who felt it had decreased ($\chi^2=9.00$, $p<0.01$).

Table 6-16: Japanese RNs-Concerns (POWCS) in the Workplace over the Last 12 Months)

Concerns		RNs n=76 [§] (%)	χ^2	df	p<0.01
The resources I have to provide care have			9.00	1	p=0.003*
	Increased	27 (39.1%)			
	Stayed about the same	33 (47.8%)			
	Decreased	9 (13.0%)			
	Missing	7			
The quality of communication with managers has			1.50	1	p=0.221
	Increased	15 (22.4%)			
	Stayed about the same	43 (64.2%)			
	Decreased	9 (13.45)			
	Missing	9			
My feeling of job security has			2.88	1	p=0.09
	Increased	5 (7.1%)			
	Stayed about the same	53 (75.7%)			
	Decreased	12 (17.1%)			
	Missing	6			
My satisfaction with my pay has			39.34	1	p<0.001**
	Increased	2(2.8%)			
	Stayed about the same	24(33.8%)			
	Decreased	45 (63.4%)			
	Missing	5			
Staffing levels have			14.24	1	p<0.001**
	Increased	6 (8.7%)			
	Stayed about the same	35 (50.7%)			
	Decreased	28 (40.6%)			
	Missing	7			

[§]:All missing data were excluded from analysis on statistical advice..*: p<0.01 **: p<0.001

Summary of Key Results

Japanese RNs reported increased stress and workloads over the last 12 months. Additionally, the negative aspects of their working environment were also reported, such as decreased staffing levels and dissatisfaction with pay. Despite the fact that there was a negative impact on the workplace and the negative aspects of work environment, RNs reported improved quality of care and more communication with patients. Additionally, they also reported that the resources they could use to provide nursing care had increased.

6.2.4 General View of Nursing Practice Environment

All RNs were asked about their nursing practice environment with 30 Likert-type questions (1: Strongly Disagree - 4: Strongly Agree) using the adapted PES-NWI. A total of 83 RNs answered these questions. The PES-NWI has 30 items to measure the hospital nursing practice environment in 5 subscales (Nurse Participation in Hospital Affairs; Nursing Foundations for Quality of Care; Nurse Manager Ability, Leadership, and Support of Nurses; Staffing and Resource Adequacy; Collegial Nurse-Physician Relations). The results are presented by each scale, and the mean scores of each scale are presented at the end (see Table 6-.21).

Nursing Participation in Hospital Affairs

All RNs were asked to comment on nurses' involvement in hospital and nursing department affairs, such as internal governance, policy decisions and committees. There were 9 items in 'Nursing Participating in Hospital'. As can be seen in Table 6-16 a great number of Japanese RNs agreed that they had ward managers who consulted with RNs daily on problems and procedures, and opportunities to serve on hospital and nursing committees. However, 77.8% of Japanese RNs reported that their Nursing Lead was not visible and accessible to them and more than 60% of RNs reported that their organisation did not listen to and respond to their concerns.

Table 6-17: PES-NWI 'Nursing Participation in Hospital Affairs' Japan

Number of Japanese RNs =83 [§]	Agree (%)	Disagree (%)	Missing data	χ^2	df	p<0.01
Our hospital has career development opportunities	70 (86.4%)	11 (13.6%)	2	42.98	1	p<0.001**
Our hospital has opportunities for staff nurses to participate in policy decisions	41 (50.6%)	40 (49.4%)	2	0.12	1	p=0.912
Our Division's Nursing Lead is highly visible and accessible to staff	18 (22.2%)	63 (77.8%)	2	25.0	1	p<0.001**
The Nursing Lead in my Division is equal in power and authority to other Divisional leads	60 (75.9%)	19 (24.1%)	4	21.28	1	p<0.001**
We have opportunities for advancement	49 (60.5%)	32 (39.5%)	2	3.57	1	p=0.059
Our organisation listens and responds to employee concerns	27 (33.3%)	54 (66.7%)	2	9.00	1	p=0.003*
Staff nurses are involved in the internal governance of the hospital (e.g. practice and policy committees)	42 (52.5%)	38 (47.5%)	3	0.20	1	p=0.655
Staff nurses have the opportunity to serve on hospital and nursing committees	73 (90.1%)	8 (9.9%)	2	52.16	1	p<0.001**
Ward managers/senior charge nurses/ward sisters consult with staff on daily problems and procedures	56 (70.9%)	23 (29.1%)	4	13.79	1	p<0.001**

[§]:All missing data were excluded from analysis on statistical advice..*: p<0.01 **: p<0.001

Nursing Foundation for Quality of Care

All RNs were asked to express their opinion on 9 items regarding staff development opportunities and the quality of management. As can be seen in Table 6-17 the majority of RNs agreed with 6 out of the 9 items. This means that most Japanese RNs in this study had a favourable opinion towards their staff development opportunities and the quality of management. However, their opinion towards the nursing system was not conclusive, as half of RNs did not believe that there was a clear philosophy, an active quality-assurance programme on a patient allocation system encouraging the continuity of care.

Table 6-18 PES-NWI 'Nursing Foundation for Quality Care' Japan

Number of Japanese RNs =83 [§]	Agree (%)	Disagree (%)	Missing data	χ^2	df	p<0.01
Our hospital has active in-service/continuing professional education programmes for nurses	67 (83.8%)	13 (16.3%)	3	36.45	1	p<0.001**
High standards of nursing care are expected by the organisation	59 (72.8%)	22 (27.2%)	2	16.90	1	p<0.001**
We have a clear philosophy of nursing that pervades the patient care environment	37 (49.3%)	38 (50.7%)	8	0.013	1	p=0.908
We are working with nurses who are clinically competent	59 (72.0%)	23 (28.0%)	1	15.8	1	p<0.001**
We have an active quality-assurance programme	33 (42.9%)	44 (57.1%)	6	1.57	1	p=0.21
We have a mentorship programme for recently qualified registered nurses	73 (89.0%)	9 (11.05)	1	49.95	1	p<0.001**
Nursing care is based on a nursing rather than a medical model	61 (78.2%)	17 (21.8%)	5	24.82	1	p<0.001**
Our nursing care plans for all patients are up-to-date and shared	58 (71.6%)	23 (28.4%)	2	15.12	1	p<0.001**
Patient allocation fosters continuity of care (i.e., the same nurse cares for the patient from one day to the next)	48 (58.5%)	34 (41.5%)	2	2.39	1	p=0.122

[§]:All missing data were excluded from analysis on statistical advice..*: p<0.01 **: p<0.001

Nurse Manager Ability, Leadership, and Support

RNs were asked to comment on their nurse manager's ability, leadership and support of RNs. As can be seen in Table 6-18 there are 5 items in 'Nurse Manager Ability, Leadership, and Support of Nurses'. Most Japanese RNs in this study agreed that they had good and supportive ward managers and managerial staff. However, more than half reported that they did not receive praise and recognition for a job well done.

Table 6-19: PES-NWI 'Nurse Manager Ability, Leadership, and Support of Nurses' Japan

Number of Japanese RNs =83 §	Agree (%)	Disagree (%)	Missing data	χ^2	df	p<0.01
Our hospital has managerial staff that are supportive of nurses	66 (82.5%)	14 (17.5%)	3	33.80	1	p<0.001**
Managers use mistakes as learning opportunities, not for criticising	49 (62.4%)	30 (38.0%)	4	4.57	1	p=0.033
We have a ward manager/senior charge nurse/ ward sister who is a good manager and leader	59 (74.7%)	20 (25.3%)	4	19.25	1	p<0.001* *
We receive praise and recognition for a job well done	30 (37.0%)	51 (63.0%)	2	5.44	1	p=0.02
We have a ward manager/senior charge nurse/ ward sister who backs up the nursing staff in decision making, even if the conflict is with a physician	60 (75.9%)	19 (24.1%)	4	21.18	1	p<0.001**

§:All missing data were excluded from analysis on statistical advice..*: p<0.01 **: p<0.001

Staffing and Resource Adequacy

‘Staffing and Resource Adequacy’ had 4 items to examine the nursing practice environment relating to staffing and resources, as can be seen in Table 6-19. There was no convincing trend on RNs’ opinion towards these 4 items regarding staffing and resource adequacy. A slightly greater number of RNs agreed that their hospital had enough staff to prioritise RNs to spend more time with patients, but RNs felt they did not have enough time to discuss patients with other staff or enough staff to provide quality care.

Table 6-20: PES-NWI ‘Staffing and Resource Adequacy’ Japan

Number of Japanese RNs =83 §	Agree (%)	Disagree (%)	Missing data	χ^2	df	p<0.01
Adequate support service allows me to spend time with my patients.	48 (59.3%)	33 (40.7%)	2	2.78	1	p=0.96
We have enough time and opportunity to discuss patient care problems with other nurses	37 (46.3%)	43 (53.8%)	3	0.45	1	p=0.502
We have enough registered nurses on staff to provide quality patient care	33 (41.3%)	47 (58.8%)	3	2.45	1	p=0.118
We have enough staff to get the work done	46 (58.2%)	33 (41.8%)	4	2.14	1	p=0.144

§:All missing data were excluded from analysis on statistical advice..*: p<0.01 **: p<0.001

Collegial Nurse-Physician Relation

RNs were asked to comment on their relationship with physicians. As can be seen in Table 6-20 there are 3 statements. RNs were asked to indicate if they agreed with the statement or not. Table 6-20 shows the percentage of RNs who agreed with the item. Significantly more ($\chi^2=14.45$, $p<0.001$) Japanese RNs agreed that there was collaboration between nurses and physicians, but not much teamwork between them.

Table 6-21: PES-NWI 'Collegial Nurse-Physician Relation' Japan

Number of Japanese RNs =83 §	Agree (%)	Disagree (%)	Missing data	χ^2	df	p<0.01
Doctors and nurses have good working relationships	45 (57.0%)	34 (43.0%)	4	1.53	1	p=0.216
There is much teamwork between nurses and doctors	38 (46.9%)	43 (53.1%)	2	0.31	1	p=0.579
We have collaboration between nurses and physicians	57 (71.3%)	23 (28.8%)	3	14.45	1	p<0.001**

§:All missing data were excluded from analysis on statistical advice..*: p<0.01 **: p<0.001

General View of Japanese RNs' Nursing Practice Environment measured by PES-NWI

As was mentioned before (4.4.6), all RNs were asked to rate their level of agreement with the sentences. The average score for each subscale (range from 1-4) and the total average score (range from 1-4) for the adapted PES-NWI are shown in Table 6-21.

The highest average score among the 5 subscales was 2.73 (Nursing Foundation for Quality of Care), and the lowest average score was 2.52 (Staffing and Resource Adequacy). The overall average score of each subscale for Japan was above 2.5. Thus the working environment for Japanese RNs in this study was categorised as 'favourable'.

Table 6-22: Average Score for Each Subscale (PES-NWI) Japan

Number of Japanese RNs =83 [§]	N	Missing data	Minimum	Maximum	Mean	SD
Nursing Participation in Hospital Affairs	77	6	1.22	3.56	2.58	0.44
Nursing Foundations for Quality of Care	69	14	1.56	3.33	2.73	0.29
Nurse Manager Ability, Leadership, and Support of Nurses	77	6	1.00	3.60	2.69	0.49
Staffing and Resource Adequacy	78	5	1.50	3.75	2.52	0.47
Collegial Nurse-Physician Relations	78	5	1.67	3.67	2.59	0.44
Total Average Score	68	15	1.80	3.23	2.64	0.32

[§]:All missing data were excluded from analysis on statistical advice

Summary of Key Results

Most Japanese RNs agreed that they had good and supportive ward managers and they also had the opportunity to serve on hospital and nursing committees. However, they had negative opinions regarding communication with the hospital. Additionally, the questionnaire results indicated inadequate staffing and resources, however the result was inconclusive. The mean score of the 5 subscales was above 2.5, which classified the Japanese nursing practice environment as 'favourable'.

6.2.5 RNs' Intention to Leave Nursing or Current Job

All RNs were asked about their intention to leave their profession and their current job. A total of 83 RNs answered these questions. As can be seen in Figure 6-6 nearly half (44.5%) of RNs thought about leaving their current job at least a few times every month and 1 in 10 Japanese RNs in this study thought about leaving their job everyday. Regarding their intention to leave the nursing profession, the proportion of RNs who thought about leaving at least a few times in the last 12 months decreased to 28.4%. Additionally, nearly half of RNs reported they had never thought about leaving the nursing profession.

Figure 6-6: Intention to Leave Current Job among Japanese Study RNs

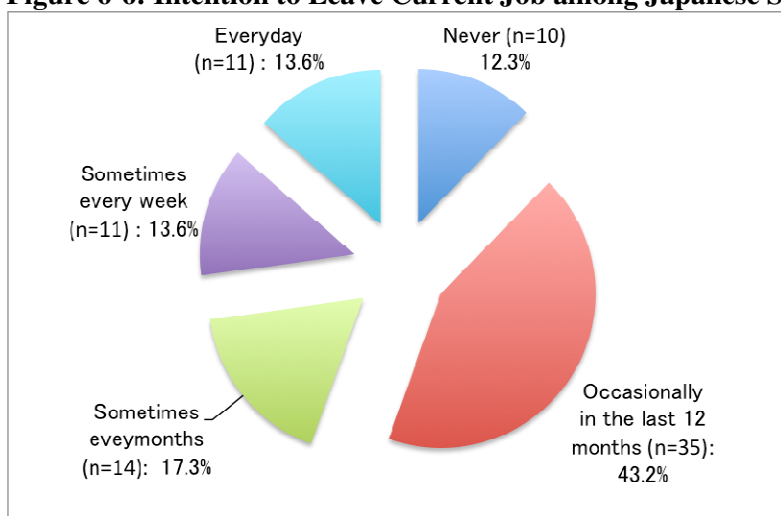
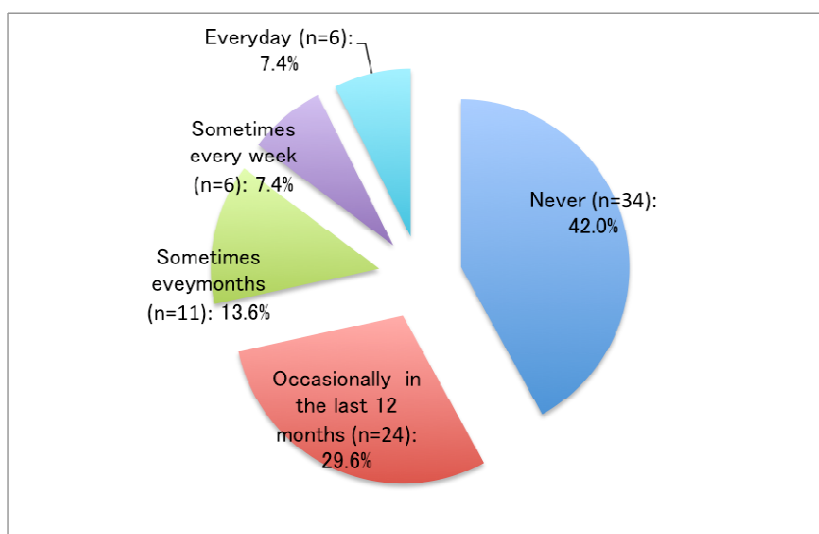


Figure 6-7: Intention to Leave Nursing Profession among Japanese Study RNs



6.2.6 Experiences of Recently Qualified Nurses in Japan

One part of the questionnaire asked RQNs about their experiences of being a RQN with 19 questions (Q24-Q41). A total of 4 RQNs who were registered for 24 months or less answered this part. Due to the small sample size (n=4), no statistical test was applied.

In Relation to Experiences as Recently Qualified Nurses

The perception of being a RQN and an organization's support during the early period of their nursing career were asked. All respondent RQNs (n=3, 1 missing data) reported that they 'always' had difficulties in familiarising themselves in clinical practice, and 2 of them were not satisfied with the organization's support. Overall, 3 of them reported their experience of being a recently qualified nurse as 'good'.

There were 3 factors that made familiarising into clinical practice difficult for RQNs. All of those who responded (n=4) reported that a lack of professional knowledge and skills, negative feelings towards their job and working environment and doubts about their ability to be a good nurse, made familiarising themselves into clinical practice very difficult.

6.3 Comparisons between Scotland and Japan

In this section, a comparison of the results is conducted.

6.3.1 Response Rate and Demographic Data

The overall response rate was 40.7% (see Table 6-22). There was no significant difference in the response rate ($\chi^2=3.60$, $df=1$, $p=0.058$) and gender distribution ($\chi^2=0.39$, $df=1$, $p=0.534$) between Scotland and Japan.

There were significant differences in the distribution of working experience in the current position (see Table 6-22). In Japan there were more RNs working in their current position for a shorter period compared to Scottish RNs. More than 80% of Japanese RNs were working in their current position for less than 5 years, whereas 58.2% of Scottish RNs were working in their current job for less than 5 years. In contrast, there was no significant difference on the length of registration among RNs in the study sites. In both countries, the majority of RNs were registered for less than 10 years. More than half of Scottish RNs (59.8%) had a degree which is more than in Japan (41.3%), making it statistically significant ($\chi^2=5.35$, $df=1$, $p=0.021$). These similarities in profiles allow comparison to be made.

Table 6-23: Profile of Questionnaire Respondents Scotland and Japan

Table 6-23. Profile of Questionnaire Respondents Scotland and Japan							
Profile		Scotland	Japan	Total	χ^2	df	p-value
Response Rate							
	Distributed	318	180	498	3.60	1	p=0.058
	Returned	120	83	203			
	Response rate	37.7%	46.1%	40.7%			
	Numbers included for calculation	119	83	202			
Sex							
	Female	96 (83.5%)	64 (80.0%)	160	0.39	1	p=0.534
	Male	19 (16.5%)	16 (20.0%)	35			
	Missing	4	3	7			
	Total	119	83	202			
Length of Working at Current Position							
	≤12months	16 (13.9%)	10 (12.5%)	26	18.00	5	p=0.003*
	13months-5years	51 (44.3%)	56 (70.0%)	107			
	6-10years	31 (27.0%)	10 (12.5%)	41			
	11-15 years	11 (9.6%)	1 (1.3%)	12			
	16-20years	3 (2.6%)	3 (3.8%)	6			
	More than 20 years	3 (2.6%)	0 (0%)	3			
	Missing	4	3	7			
	Total	119	83	202			
Length of Registration							
	≤24months	13 (11.3%)	4 (5.0%)	17	6.73	5	p=0.241
	2-5years	36 (31.3%)	28 (35.0%)	64			
	6-10 years	33 (28.7%)	31 (38.8%)	64			
	11-15 years	12 (10.4%)	9 (11.3%)	21			
	16-20 years	9 (7.8%)	5 (6.3%)	14			
	More than 21 years	12 (10.4%)	3 (3.8%)	15			
	Missing	4	3	7			
	Total	119	83	202			
Educational Background							
	Pre-registration Diploma (Scotland)	11 (9.8%)	NA	55	5.35	1	p=0.021
	Nursing School Diploma (Japan)	NA	28 (35.0%)				
	Post-registration Diploma (Scotland)	17 (15.2%)	NA	17			
	Junior Degree Diploma (Japan)	NA	16 (20.0%)				
	Degree	67 (59.8%)	33 (41.2%)	100			
	Master	4 (3.6%)	3 (3.8%)	7			
	Other	13 (11.6%)	0 (0%)	13			
	Missing	7	3	10			
	Total	119	83	202			

*: p<0.01 **: p<0.001

6.3.2 Awareness of Policies Related to RNs' Clinical Practice

According to the results presented in the previous sections (6.1.2 and 6.2.2), there are several similarities regarding the awareness of policies related to RNs' clinical practice. Firstly, the most common answer for each question was 'to some degree', and more than half of RNs in both countries were aware of their government policies related to health policy and nursing workforce planning. Additionally, they were aware of the impact of these government policies.

However, the differences between these answers for the 2 questions were significantly different. In Scotland, 97% of RNs were aware of government health policies related to their area of practice, compared to 70% of Japanese RNs. In detail, nearly 30% of Scottish RNs were aware of government health policies related to their clinical area in great depth compared to only 3% of Japanese RNs. Similar results can be seen in answer to the question about the degree of impact of government policies on clinical practice. Almost all of Scottish RNs aware of the impact of government policies in clinical practice, where as 18.8% of Japanese RNs were not aware of the impacts on their clinical practice at all.

Table 6-24: Differences between Scotland and Japan in the Awareness of Policies and their Impact on the Clinical Area

Number of RNs		Scotland [§] (%) (n=102)	Japan [§] (%) (n=76)	χ^2	df	p<0.01
Awareness of government health policies related to clinical practice						
Not at all	3 (3.0%)	19 (27.5%)	34.11	2	p<0.001**	
To some degree	69 (68.3%)	48 (69.6%)				
Very much	29 (28.7%)	2 (2.9%)				
Missing data	1	7				
Awareness of government policies related to nursing workforce planning						
Not at all	18 (17.8%)	26 (37.7%)	9.70	2	p=0.008*	
To some degree	74 (73.3%)	41 (59.4%)				
Very much	9 (8.9%)	2 (2.9%)				
Missing data	1	7				
The degree of the impact of government policies on clinical practice						
Not at all	3 (3.0%)	13 (18.8%)	22.84	2	p<0.001**	
To some degree	57 (57.6%)	48 (69.6%)				
Very much	39 (39.4%)	8 (11.6%)				
Missing data	1	7				

[§]:All missing data were excluded from analysis on statistical advice..*: p<0.01 **: p<0.001

6.3.3 Perceived Change in the Workplace over the Last 12 Months

In this section, a comparison of the results of perceived change in the workplace over the last 12 months between Scotland and Japan is presented.

Similarities in Changes in the Workplace over the Last 12 Months

According to the results presented in the previous sections (6.1.3 and 6.2.3), there are several similarities in the results of this part of questionnaire. Firstly, both countries showed in 'Pressure' that more than half of the RNs felt the level of stress and workload had increased over the last 12 months, and secondly, despite the increased pressure in the workplace, more RNs (Scotland: 38.0%, Japan: 44.3%, respectively) reported improved quality of care compared to those RNs who reported a deteriorated quality of care (12.0%, 12.9%).

Table 6-25: Similarities in POWCS -Perceived Change in the Workplace over the Last 12 Months

Number of RNs		Scotland (n=102) [§]				Japan (n=76) [§]			
Pressure		n (%)	χ^2	df	p<0.01	n(%)	χ^2	df	p<0.01
The levels of stress I feel have									
	Increased	54 (54.0%)	22.04	1	p<0.001**	40 (56.3%)	12.52		p<0.001**
	Stayed about the same	31 (31.0%)				17 (23.9%)			
	Decreased	15 (15.0%)				14 (19.7%)			
	Missing data	2				5			
My workload has									
	Increased	57 (57.0%)	36.94	1	p<0.001**	37 (53.6%)	20.45		p<0.001**
	Stayed about the same	35 (35.0%)				25 (36.2%)			
	Decreased	8 (8.0%)				7 (10.1%)			
	Missing data	2				7			
Strength									
The quality of care I am able to give									
	Increased	38 (38.0%)	13.52	1	p<0.001**	31 (44.3%)	12.10		p<0.001**
	Stayed about the same	50 (50.0%)				30 (42.9%)			
	Decreased	12 (12.0%)				9 (12.9%)			
	Missing data	2				6			
Concerns									
The resources I have to provide care have									
	Increased	35 (34.7%)	8.00	1	p=0.005*	27 (39.1%)	9.00		p=0.003*
	Stayed about the same	51 (50.5%)				33 (47.8%)			
	Decreased	15 (14.9%)				9 (13.0%)			
	Missing data	1				7			

[§]:All missing data were excluded from analysis on statistical advice.*: p<0.01 **: p<0.001

Differences in Changes in the Workplace over the Last 12 Months

In contrast, there are 5 variables that showed a statistical difference in the distribution of the RNs' answers among Scotland and Japan (Table 6-26).

Generally, more Scottish and Japanese nurses felt their responsibility had 'increased' rather than 'decreased'. A higher proportion of Scottish RNs (64.4%) reported that their responsibilities had 'increased' compared to Japanese RNs (38.0%). However, a greater proportion of Scottish RNs (56.4%) reported that morale had 'decreased' compared to Japanese RNs (32.9%).

Half of the Japanese RNs did not experience any change in their feeling of being a valued employee, whereas almost half of Scottish RNs (45.5%) felt their value had decreased. More than double the number of Scottish RNs (36.0%) felt the quality of communication with managers had decreased whereas Japanese RNs (64.2%) felt their communication with managers had not changed. The amount of time RNs had to talk to patients had decreased compared to Japanese RNs who were about 3 times more likely (33.8%) to feel they had more time to talk to patients.

Table 6-26: Differences in POWCS -Perceived Change in the Workplace over the Last 12 Months

Number of RNs		Scotland (%) n=102 [§]	Japan (%) n=76 [§]	χ^2	df	p<0.01
Pressure						
My responsibilities have						
	Increased	65 (64.4%)	27 (38.0%)	11.63	2	p=0.003*
	Stayed about the same	25(24.8%)	30 (42.3%)			
	Decreased	11 (10.9%)	14 (19.7%)			
	Missing data	1	5			
Strength						
My feelings of being a valued employee have						
	Increased	27(26.7%)	21(29.6%)	14.01	2	p=0.001*
	Stayed about the same	28 (27.7%)	36 (50.7%)			
	Decreased	46 (45.5%)	14 (19.7%)			
	Missing data	1	5			
The amount of time I have to talk to patients has						
	Increased	12(11.9%)	24 (33.8%)	13.95	2	p=0.001*
	Stayed about the same	62 (61.4%)	38 (53.5%)			
	Decreased	27 (26.7%)	9 (12.7%)			
	Missing data	1	5			
The morale of my colleagues has						
	Increased	18 (18.0%)	14 (20.0%)	10.14	2	p=0.006*
	Stayed about the same	26 (26.0%)	33 (47.1%)			
	Decreased	56 (56.0%)	23 (32.9%)			
	Missing data	2	6			
Concerns						
The quality of communication with managers has						
	Increased	20 (20.0%)	15 (22.4%)	10.83	2	p=0.004*
	Stayed about the same	44 (44.0%)	43 (64.2%)			
	Decreased	36 (36.0%)	9 (13.4%)			
	Missing data	2	9			

[§]:All missing data were excluded from analysis on statistical advice. .*: p<0.01 **: p<0.001

Summary of Key Results

In both countries the levels of stress and workload had increased. However, study RNs reported improved availability of resources to provide care and improved quality of care that they were able to provide. More positive changes related the communication with patients and managers at the workplace were identified only among Japanese RNs. In contrast, Scottish RNs reported negative changes in relation to communication with patients and managers. Additionally, Scottish RNs reported their feeling of being a valued employee had decreased, whereas Japanese RNs reported that it had increased.

6.3.4 General View of Nursing Practice Environment

A comparison was made first between Scotland and Japan for each subscale and then each subscale score was compared by the *t*-test (two-tailed) (Table 6-27)

Nurse Participation in Hospital Affairs

There are 3 variables that showed significant differences in the distribution between Scotland and Japan in this subscale. Firstly, Scottish Nursing Leads were generally perceived to be more visible and accessible to RNs than the Japanese Leads because a greater proportion of Scottish RNs (54.3%) agreed that their Division's Nursing Lead was highly visible and accessible to staff compared to Japanese RNs (22.2%). Secondly, Japanese RNs (90.1%) reported that they have opportunities to serve hospital committees. Thirdly, Japanese RNs agreed that they had opportunity for development (86.4%).

On the other hand, there were several similarities in the portion of RNs who disagreed with their nursing practice environment. In both countries, half of RNs did not get any praise for a job well done and they were not given the opportunity to be involved hospital policy decisions or internal governance.

Table 6-27: PES-NWI ‘Nursing Participation in Hospital Affairs’ Scotland and Japan

	Percentage Agreeing		χ^2	df	p<0.01
Number of RNs	Scotland (n=119) [§] (%)	Japan (n=83) [§] (%)			
Nurse Participation in Hospital Affairs					
Our hospital has career development opportunities	71 (60.7%)	70 (86.4%)	15.46	1	p<0.001**
Our hospital has opportunities for staff nurses to participate in policy decisions	50 (43.5%)	41 (50.6%)	0.97	1	p=0.324
Our Division’s Nursing Lead is highly visible and accessible to staff	63 (54.3%)	18 (22.2%)	20.28	1	p<0.001**
The Nursing Lead in my Division is equal in power and authority to other Divisional leads	70 (69.3%)	60 (75.9%)	0.98	1	p=0.323
We have opportunities for advancement	52 (45.6%)	49 (60.5%)	4.20	1	p=0.04
Our organisation listens and responds to employee concerns	47 (41.6%)	27 (33.3%)	1.36	1	p=0.243
Staff nurses are involved in the internal governance of the hospital (e.g. practice and policy committees)	53 (48.6%)	42 (52.5%)	0.277	1	p=0.598
Staff nurses have the opportunity to serve on hospital and nursing committees	61 (57.0%)	73 (90.1%)	24.69	1	p<0.001**
Ward managers/senior charge nurses/ ward sisters consult with staff on daily problems and procedures	87 (75.7%)	56 (70.9%)	0.55	1	p=0.459

[§]:All missing data were excluded from analysis on statistical advice.*: p<0.01 **: p<0.001

Nursing Foundation for Quality Care

In both countries, almost all study RNs agreed that there was a mentorship programme for recently qualified nurses and more than 70% agreed that they were working with clinically competent nurses. There are 4 variables that showed a significant difference in the distribution between Scotland and Japan. Generally, more Scottish RNs agreed with the items in this subscale. Regarding the nursing quality and care delivery, more Scottish RNs agreed that they had a clear philosophy of nursing and their nursing care plans were updated and shared compared to Japanese RNs. In addition, more than half of Scottish RNs stated that they had an active quality-assurance programme, whereas less than half of Japanese RNs agreed with this.

Table 6-28: PES-NWI 'Nursing Foundation for Quality Care' Scotland and Japan

	Percentage Agreeing		χ^2	df	p<0.01
Number of RNs	Scotland (n=119) [§] (%)	Japan (n=83) [§] (%)			
Nursing Foundation for Quality Care					
Our hospital has active in-service/ continuing professional education programmes for nurses	87 (74.4%)	67 (83.8%)	2.46	1	p=0.117
High standards of nursing care are expected by the organisation	106 (91.4%)	59 (72.8%)	12.05	1	p=0.001*
We have a clear philosophy of nursing that pervades the patient care environment	91 (79.8%)	37 (49.3%)	19.24	1	p<0.001**
We are working with nurses who are clinically competent	93 (80.9%)	59 (72.0%)	2.16	1	p=0.142
We have an active quality-assurance programme	76 (68.5%)	33 (42.9%)	12.24	1	p<0.001**
We have a mentorship programme for recently qualified registered nurses	111 (97.4%)	73 (89.0%)	5.78	1	p=0.016
Nursing care is based on a nursing rather than a medical model	89 (78.1%)	61 (78.2%)	0.000	1	p=0.982
Our nursing care plans for all patients are up-to-date and shared	94 (82.5%)	58 (71.6%)	3.24	1	p=0.072
Patient allocation fosters continuity of care (i.e., the same nurse cares for the patient from one day to the next)	86 (76.1%)	48 (58.5%)	6.82	1	p=0.009*

[§]:All missing data were excluded from analysis on statistical advice. *: p<0.01 **: p<0.001

Nurse Manager Ability, Leadership and Support of Nurses

Generally, both countries' RNs stated that they had a good manager and leader who backed up the nursing staff when necessary. Additionally, most Japanese RNs (82.5%) agreed that they had supportive managerial staff in the hospital compared to only half of Scottish RNs. Despite the relatively favourable opinion towards their manager or leader, more than half RNs in each country stated that they did not receive praise and recognition for a job well done.

Table 6-29: PES-NWI 'Nurse Manager Ability, Leadership and Support of Nurses' Scotland and Japan

	Percentage Agreeing		χ^2	df	p<0.01
Number of RNs	Scotland (n=119) [§] (%)	Japan (n=83) ^{§§} (%)			
Nurse Manager Ability, Leadership and Support of Nurses					
Our hospital has managerial staff that are supportive of nurses	58 (50.4%)	66 (82.5%)	20.95	1	p<0.001**
Managers use mistakes as learning opportunities, not for criticising	71 (60.7%)	49 (62.4%)	0.04	1	p=0.85
We have a ward manager/senior charge nurse/ ward sister who is a good manager and leader	101 (85.6%)	59 (74.7%)	3.69	1	p=0.055
We receive praise and recognition for a job well done	49 (41.9%)	30 (37.0%)	0.47	1	p=0.494
We have a ward manager/senior charge nurse/ ward sister who backs up the nursing staff in decision making, even if the conflict is with a physician	95 (83.3%)	60 (75.9%)	1.61	1	p=0.205

[§]:All missing data were excluded from analysis on statistical advice. *: p<0.01 **: p<0.001

Staffing and Resource Adequacy

As can be seen in Table 6-28, fewer Japanese RNs agreed with the items in this subscale. A majority (81.0%) Scottish RNs perceived that their hospital prioritise RNs to spend time with patients compared to 59.3% of Japanese RNs. More Scottish RNs (70.7%) thought that they had enough staff to provide quality patient care compared to Japanese RNs (41.3%). Interestingly, less Scottish RNs (43.5%) stated that they had enough staff to get the work done whereas more Japanese RNs (58.2%) thought they had enough staff.

Table 6-30: PES-NWI ‘Staffing and Resource Adequacy’

	Percentage of Agreeing		χ^2	df	p<0.01
Number of RNs	Scotland (n=119) [§] (%)	Japan (n=83) ^{§§} (%)			
Staffing and Resource Adequacy					
Our hospital believes that it is important for me to spend more time with my patients (Adequate support service allows me to spend time with my patients.)	94 (81.0%)	48 (59.3%)	11.24	1	p=0.001*
We have enough time and opportunity to discuss patient care problems with other nurses	73 (61.9%)	37 (46.3%)	4.71	1	p=0.03
We have (Our ward has) have enough registered nurses on staff to provide quality patient care	82 (70.7%)	33 (41.3%)	16.92	1	p<0.001**
We have (Our hospital has) enough staff to get the work done	50 (43.5%)	46 (58.2%)	4.08	1	p=0.044

[§]:All missing data were excluded from analysis on statistical advice. .*: p<0.01 **: p<0.001

Collegial Nurse-Physician Relations

In Scotland, good working relationships and teamwork between nurses and doctors were reported by most RNs (75.7%, 70.2% respectively). On the other hand, fewer Japanese RNs (57.0%, 46.9% respectively) stated that they had good working relationships and teamwork. However, more Japanese RNs (71.3%) agreed that there were collaborations between nurses and physicians despite the fact that not as many Japanese RNs agreed that there were good working relationships and teamwork compared to Scottish RNs.

Table 6-31: Percentage of RNs who agree with items for 'Collegial Nurse-Physician Relations' and the Result of Chi-square Test

	Percentage Agreeing		χ^2	df	p<0.01
Number of RNs	Scotland (n=119) [§] (%)	Japan (n=83) ^{§§} (%)			
Collegial Nurse-Physician Relations					
Doctors and nurses have good working relationships	87 (75.7%)	45 (57.0%)	7.52	1	p=0.006*
There is much teamwork between nurses and doctors	80 (70.2%)	38 (46.9%)	10.72	1	p=0.001*
We have collaboration between nurses and physicians	74 (65.5%)	57 (71.3%)	0.71	1	p=0.398

[§]:All missing data were excluded from analysis on statistical advice. .*: p<0.01 **: p<0.001

General View of Scottish RNs' Nursing Practice Environment measured by PES-NWI

The following table shows the *t*-test (2-tailed) of the average score for each subscale and the total average score in Scotland and Japan. There was a significant difference on the subscale 'Nursing Foundation for Quality of Care'. The classification of the nursing practice environment in both countries was 'favourable'.

Table 6-32: T-test (2-tailed) for the Average Total Score and Subscale Score for PES-NWI

Subscale and total average score (number of items)	Scotland (n=119) [§] Mean	Japan (n=83) [§] Mean	p<0.01
Nursing Participation in Hospital Affairs (9)	2.51	2.58	p=0.347
Nursing Foundation for Quality of Care (9)	3.06	2.73	p<0.001**
Nurse Manager Ability, Leadership and Support of Nurses (5)	2.68	2.69	p=0.931
Staffing and Resource Adequacy (4)	2.72	2.52	p=0.014
Collegial Nurse-Physician Relations (3)	2.77	2.59	p=0.023
<i>Total Average Score</i>	2.74	2.64	p=0.133

[§]:All missing data were excluded from analysis on statistical advice. .*: p<0.01 **: p<0.001

6.3.5 RNs' Intention to Leave Nursing and Current Job

Table shows all RNs' intention to leave their profession and their current job in Scotland and Japan. Statistical tests showed no significant difference on the distribution of the frequency of their thoughts of leaving nursing ($\chi^2=4.34$, $df=4$, $p=0.362$) or their current job ($\chi^2=2.10$, $df=4$, $p=0.718$). The majority of study RNs in Scotland and Japan reported that they had thought about leaving their current job at least once in the last 12 months, but nearly half of them never thought about leaving nursing in the last 12 months.

Table 6-33: Intention to Leave Current Job and Nursing Profession among Scottish & Japanese RNs and the Result of Chi-square Test

Number of RNs	Scotland (n=119) [§] (%)	Japan (n=83) [§] (%)	χ^2	df	p<0.01
Intention to leave current job			2.10	4	p=0.718
Never	23(19.7%)	10 (12.3%)			
Occasionally in the last 12 months	48 (41.0%)	35 (43.2%)			
Sometimes every month	19 (16.2%)	14 (17.3%)			
Sometimes every week	15 (12.8%)	11 (13.6%)			
Everyday	12 (10.3%)	11 (13.6%)			
Missing data	2	2			
Intention to leave nursing			4.34	4	p=0.362
Never	48 (41.0%)	34 (42.0%)			
Occasionally in the last 12 months	44(37.6%)	24 (29.6%)			
Sometimes every month	11 (9.4%)	11 (13.6%)			
Sometimes every week	11(9.4%)	6 (7.4%)			
Everyday	3 (2.6%)	6 (7.4%)			
Missing data	2	2			

[§]:All missing data were excluded from analysis on statistical advice. .*: p<0.01 **: p<0.001

6.3.6 Section 2: Nurses Registered for 24 Months or Less

Due to the small number of respondents in this section, no comparisons were applied.

Chapter 7: Discussion

7.1 Introduction

Two single case studies were conducted to investigate the government policies related to nursing workforce planning focused on recently qualified nurses and their impact on the critical care nursing workforce in Scotland and Japan.

There were five research questions that were developed at the beginning of this study (2.10).

1. What government-driven policy exists to maintain the recently qualified nursing workforce in Scotland and Japan?
2. To what extent are registered nurses in clinical practice aware of these policies?
3. What are the responses of clinical practice to these workforce policies?
4. Do nurse managers and RQNs have issues and/or concerns related to these workforce policies?
5. Can an understanding of questions 1-4 suggest how policies related to RQNs could be better developed and implemented?

Firstly, the profile of RNs in Scotland and Japan are discussed and then the research questions are answered. The findings and results are first discussed separately and then similarities and differences between Scotland and Japan are discussed based on the comparisons. Then, methodological issues are discussed. As many issues emerged during the research process, in particular conducting a study in two different countries, reflections on the study process are presented. Finally, study limitations are discussed.

7.2 Profile of Registered Nurses from Questionnaires

In this study, Scottish RNs were predominantly female, (83.5%) had worked in their current position for 1-5 years (44.3%), had been registered for 2-5 years (31.3%), and had a degree (59.8%). On the other hand, Japanese RNs were predominantly female (80%), had

worked in their current position for between 1-5 years (70.0%), had been registered for 6-10 years (38.8%), and had a degree (41.2%).

There were more Japanese RNs with less experience in critical care settings compared to Scottish RNs. However, there was no difference in the profile of length of registration. The difference can be explained by the age profile of Japanese RNs and the different employment style. As it was mentioned (2.6.6 and 2.7.6), 25% of Japanese RNs were younger than 30 years old (MHLW, 2011b), whereas only 10% of UK RNs were aged 30 or younger (Nursing and Midwifery Council, 2008). The young profile of Japanese RNs with less experience was also mentioned in the literature (Kanai-Pak et al., 2008) as more than half of RNs were aged younger than 30 years with less than 10 years of clinical experience. Other reasons could be the employment style of RNs. In Japan, RNs were employed by each hospital, not by each ward, and it is common that they rotate wards from time to time. Thus, it is understandable that there are RNs with less experience in the critical care settings, but there was not a big difference their length of registration between Scotland and Japan.

7.3 Answering the Research Questions

There were five research questions that this research intended to answer. The first research question was to be answered by the literature review. The second, third, and fourth questions were answered fully. The last question is answered partially through the answers to the previous research questions.

7.3.1 Government Policies related to Recently Qualified Nurses

All nursing workforce planning policies were not identified fully in this study due to the large volume of literature. However, policies related to nursing workforce planning targeted at or related to recently qualified nurses were identified by the literature review for at least the last five years (2.5.7 and 2.6.7).

In Scotland, there are three initiatives that are targeted at recently qualified nurses:

- One Year Job Guarantee (Scottish Executive, 2002)
- Flying Start (NES, 2006)

- Early Clinical Career Fellowships (NES, 2008).

In Japan, there were two major legislative changes that made a huge impact on the recently qualified nursing workforce (2.6.7):

- Change in the Medical Care Fee Schedule for Remuneration (Central Social Insurance Medical Care Committee, 2005)
- Change in the ‘Public Health Nurses, Midwives, and Nurses Act’ and ‘Nurse Provision Act’ (MHLW, 2009c; MHLW, 2009f).

Additionally, several key government policies related to nursing workforce planning were also identified in each country. The following table shows the health policy and their goals in Scotland and Japan. These tables are provided for discussion later in this section and answer research question 1.

Table 7-1: Key Policies and their Goals in Scotland and Japan

Scotland	Japan
<p>Building a Health Service Fit for the Future (2005)</p> <ul style="list-style-type: none"> • Ensuring a sustainable and safe local service • Delivering the service in local communities rather than in hospitals • Drawing attention to preventative, anticipatory care rather than reactive management • Engaging people (not only NHS employers, but also patients and their carers) in changes to meet the challenge • Applying modern technology to improve the service and the speed of delivering care • Developing new skills and roles to support local services • Involving the public more in the process of developing solutions <p>Delivering for Health (2005)</p> <ul style="list-style-type: none"> • Shift NHS from an acute hospital-centred to a community-based service • Tackle the two challenges of an ageing population and associated incidence of long-term conditions • Enhance the preventative health service rather than reacting to illness • Treat people faster and closer to home • Develop a health service that is proactive, modern, safe and embedded in communities <p>Better Health Better Care (2007)</p> <ul style="list-style-type: none"> • Health improvement (smoking, alcohol misuse, obesity, and mental health) • Tackling health inequality (pregnant women, babies and young children to cut the link between early life difficulties and adult disease) • Improving the quality of health care ('needed care' should be as local as possible to the community it was serving) 	<p>Vision of a Reformation in Healthcare Service Delivery System (2003)</p> <ul style="list-style-type: none"> • To improve the delivery of information regarding healthcare services for patients • To secure local healthcare services • To promote specialisation and collaborations between healthcare providers • To improve the quality of the healthcare professions (medical doctors, NMAHPs) and their retention and recruitment • To maintain and improve the foundation of the healthcare service <p>Vision of a Secured and Reliable Healthcare Service (2008)</p> <ul style="list-style-type: none"> • Maintaining the appropriate number of healthcare professionals and review of their roles • Establishing a healthcare service network in each local area • Collaboration between healthcare professionals, patients, and their family members

Summary

As can be seen from the literature review and Table 7-1, the first research question was answered fully. Additionally, it was identified that attention was paid to RQNs in both countries in terms of nursing workforce planning.

7.3.2 RNs' awareness of Workforce Policies in Scotland and Japan (Research Question 2)

The importance of nurses' involvement in policy was emphasised by Toofany (2005) and Hewison (2007). Additionally, it was argued that the consensus of policy change among implementers have had an impact on how effectively the policy is implemented (Van Meter and Van Horn, 1975). In this study, Scottish RNs' awareness of policies and the impact of these policies was greater than Japanese awareness (6.1.3 and 6.2.3), and this could be explained by the following factors; 1) the structure of the healthcare system in each country (2.5.4 and 2.6.4), and 2) perceptions and understanding of government initiatives among nurse managers and ward managers.

First of all, the organisational structure of the healthcare service in each country and government approaches towards policy implementation might have had some impact on RNs' awareness of policies and impact. For example, there is a structural difference as to how Scotland and Japan implement policy. The Scottish approach was a broader organisational approach presenting detailed action plans for change (Scottish Executive, 2005a; NES, 2006; Scottish Government, 2007a)(2.5.7 and 2.6.7), reflects a 'top-down' approach (2.9.2) . In other words, the policy change was brought down from the top to bottom of the NHS structure with a clear action plan and views. On the other hand, the Japanese approach was based on the individual hospital's effort towards the policy goals, and where legislative change was often used as incentive (Central Social Insurance Medical Care Committee, 2005), reflects a 'bottom-up' approach. The other example is that the healthcare service in Scotland is mostly provided by NHS Scotland (European Observatory on Health Care Systems, 1999; OECD, 2011), whereas the Japanese healthcare service is provided by the public and private sectors (MHLW, 2010b). Additionally, Scottish RNs were employed by the NHS whereas Japanese RNs were employed by each hospital. Therefore, there might be more a direct and stronger influence of government policies on Scottish clinical nursing practice, whereas there might not be as much influence on the ward level in Japan. Therefore, Japanese RNs might have had less awareness of policies and the impact of these policies in their clinical practice as well as interest in policies compared to Scottish RNs.

Secondly, the understanding and perceptions of government policies among nurse managers and ward managers might have had some impact on RNs' awareness of policies. As discussed in the literature (2.9), the importance of consensus of policy goals among

target group and implementers was emphasised (Elmore, 1978; Van Meter and Van Horn, 1975). Most Scottish managers seemed to have more understanding of policy background and policies compared to some Japanese managers. For example, Scottish nurse managers emphasised the importance of engagement among RNs with policies and expected RNs to understand the policy background (5.3.1 and 5.4.1). During the interviews with managers, several policies were mentioned and themes emerged from their perceptions and experience of these policies. On the other hand, there was a variation among Japanese nurse managers in terms of understanding policy background and policies. For example, some Japanese ward managers misunderstood the background of international recruitment (MHLW, 2009a) (2.7.6) as some thought international recruitment was one of the main strategies for nursing workforce planning in Japan. These differences in understanding of policies among nurse managers between Scotland and Japan might have had some influence on the degree of awareness among RNs, and the disparity of the level of policy understanding among might have been influenced by the organisational structure of healthcare system in Scotland and Japan.

In relation to the differences in understanding of policies among managers between Scotland and Japan, there was a variation between nurse managers and ward managers (5.10.1 and 5.10.2). As might have been expected, nurse managers had a more broad view towards nursing workforce policies compared to ward managers. For example, Scottish ward managers had a great understanding of policies directly related to them or their ward's daily clinical practice such as the 'Senior Charge Nurse Review' (5.3.1 and 5.4.1), whereas nurse managers had broader interests in nursing workforce policies in NHS Scotland. Similarly, the difference between nurse managers and ward managers was visible in Japan (5.10.2). Ward managers' interests in nursing workforce policies were greatly related to the events in their ward, whereas nurse managers' understanding and perceptions of nursing workforce policies were broader and including some issues related to Japanese nursing such as the need for a registration system (5.7.1).

Summary

The second research question was answered fully. More Scottish RNs were aware of the policies related to RQNs and their impact on clinical practice compared to Japanese RNs. The healthcare system in both countries and the understanding of policies among managers could explain the difference in awareness of policies between Scotland and Japan.

7.3.3 The Responses to Scottish Policies related to RQNs (Research Questions 3)

The responses to policies were investigated by questionnaires and the interviews. The questionnaire provided general views of changes in the workplace and the nursing practice environment and the interviews provided perceptions and understanding of policies related to RQNs.

Perceptions of FS and ECCFs among Nurse Managers and RQNs

‘Flying Start’ (FS) was launched to support all newly qualified NMAHPs during their transition process. FS provided 10 learning components and RQNs work through these components in their own time (2.5.7). ‘Early Clinical Career Fellowships’ were commissioned and lead by NES in 2008. The government objective of this programme was to identify and support talented and motivated RNs to develop their skills and careers (NES, 2008) (2.5.7). There are two national evaluation studies of FS and ECCFs. The findings of this study support some of the findings of these evaluation studies including Banks et al (2010) and Pearson and Atkinson (2010), and did not contradict those evaluation studies. Detailed examples are given in the following sections as well as other literature that the findings of this study are supporting for.

Fulop et al (2012) argue that how changes are perceived among stakeholders influence the process and the result of implementation. Van Meter and Van Horn (1975) also argued that the implementation process varies depending on the nature of the policy to be carried out and the types of policy, which are classified by the amount of change and the degree of consensus among the participants in implementation process. In this study, there were positive and negative perceptions among managers and RQNs towards FS. The most common understanding and perception among managers about the government intention of ‘Flying Start’ and ‘Early Clinical Career Fellowships’ was ‘support’ (5.2.2 and 5.3.2), which could fill the gap between being a student and being a qualified nurse and provide the opportunity to develop a career at an early stage (NES, 2008). FS was implemented in most clinical practice in this study by combining it with the ward-based competency book (5.2.2). Most nurse managers understood the government intention and saw the beneficial aspect of FS. As emphasised in some literature (Higgins et al., 2010; O’Kane, 2012), nurse managers were well aware of the importance of providing support to RQNs.

On the other hand, there was a misfit between the government's intentions and how FS was perceived by managers and RQNs. For example, RQNs did not find FS particularly helpful in terms of supporting their transition process (5.4.2), and managers did not receive good feedback from RQNs on FS. They both had some doubt on the content of FS. A misfit between government intention and how FS was perceived could be explained by two key aspects of FS; 1) the impact of implementing FS in clinical practice, 2) the content of FS.

In this study, the workload and work environment of the critical care setting was highlighted when FS was perceived as an obstacle for RQNs to progress in clinical practice. The amount of changes by the policy is an affecting factor of policy implementation (2.9). Managers thought FS might delay other training RQNs needed to be doing. FS requires self-directing study for RQNs to complete and involves other staff members as their mentor in some exercises within FS (NES, 2006). Therefore these changes due to FS were perceived as additional workload among some managers and RQNs. For instance, several managers reported that RQNs were required to spend a number of hours on training and familiarising themselves with clinical practice rather than working on FS and, in addition, RQNs reported that they had some difficulties in time management because of the workload and staffing (5.2.3). Time management, the concept of which can be also seen in the themes and categories (5.2.3 and 5.3.2), was reported as one of the issues in the evaluation study by Banks et al (2010) (Table 2-7). O'Kane (2012) also highlighted a difficulty of managing time during the transition process among RQNs working in ICU. As might have been expected, work environment factor could be an important factor in terms of implementing changes into clinical practice. Completing FS in critical care settings might be more challenging compared to other clinical practice areas, not only because of the issues discussed above, but also the nature of critical care settings. In this study, some managers thought that starting a career in critical care units and at the same time working on FS could overwhelm RQNs (5.3.2). However, O'Kane (2012) argued that ICU might be a good area to start their nursing career as there are good supports. In this study, some findings could support O'Kane's argument as some RQNs expressed their appreciation for their work environment including the support from other members of staff (5.4.1).

The other key aspect of FS that could be an explanation of misfit between government and negative perceptions among managers and RQNs is the content of FS. Fulop et al (2012) argued the drivers for and content of changes influence the result of implementation in. In addition to overwhelming RQNs during the transition process, managers and RQNs had

some doubt on the content of FS (5.3.2). These concepts were found in 'Doubt about the Practicality and Effectiveness' (5.3.2) and 'Flying Start is boring and not helpful' (5.4.2). For example, RQNs thought some of the topics in FS were quite repetitive because they were covered in university courses as well as being too generalised. There are not surprising findings because FS was targeted at all NMAHPs to support their transition process. Therefore, there was no scope for nursing specialities. A survey conducted by the Japanese Nursing Association revealed that one of the key piece of knowledge that RQNs are eager to gain at their transition period was professional knowledge (JNA, 2004b). Even though the government did not develop FS to target individual clinical needs (NES, 2006), managers and RQNs expected it to be more specific or more clinical practice focused. In other words, FS did not reflect the clinical needs of specific areas.

Perceptions of Scottish Nursing Workforce Policies among Nurse Managers

General responses to Scottish nursing workforce policies among nurse managers varied. Nurse managers seemed to have more understanding towards government initiatives, as well as the policy background (5.3.1 and 5.10.1). In contrast, ward managers seemed to have more negative perception towards government policies (5.4.1 and 5.10.1), in particular how the changes were brought into their clinical practice. This is not surprising because ward managers seemed to have more responsibilities of implementing policies into clinical practice. Additionally, they were probably less involved much in the process of policy development. Even though ward managers understood the policies to some degree, they seemed to struggle with implementing policies due to the lack of support and resources.

Perceived Change at the Workplace in relation to Scottish Policies

Better work environment (Aiken et al., 2008; Kanai-Pak et al., 2008) (2.3.4), nurse staffing (Aiken et al., 2002b) (2.3.3), and nurses' profile (Aiken et al., 2003) (2.3.5) were recognised as important factors related to the patient's outcome and RNs' intention to leave nursing (2.3.6). UK nursing workforce policies focused on improving retention and recruitment by improving these factors such as work environment, management, support and leadership (Attree et al., 2011) (2.5.1). The impact of government attempts for nursing workforce could be seen in the results of the POWCS (6.1.3) and PES-NWI (6.1.4), such as RNs' perceptions of their managers and staffing level.

Firstly, RNs had better views towards ward managers than managers in general. This might be explained by the responses to the 'Senior Charge Nurse Review'. The 'Senior Charge Nurse Review' was mentioned in the interviews as an example of policy implementation and the changes that were brought to the role of ward managers (5.3.1). There might be some relationship between RNs' perception of managers and this policy 'Senior Charge Nurse Review'. According to the PES-NWI (6.1.4), half of Scottish RNs reported managers in the hospital were not supportive and their Nursing Lead was not visible or accessible (6.1.4). Additionally, half of Scottish RNs perceived their quality of communication with managers had not changed over the 12 months (6.1.3). However, RNs had a positive view towards 'ward' managers. Most reported that they had good and supportive ward managers (6.1.4). These results suggested that Scottish RNs perceived their managers (including ward managers) differently in accordance to how close managers were to RNs. Scottish RNs seemed to have a positive perception towards their closest managers (ward managers), but not with the managers in higher positions.

Secondly, Scottish RNS perceived their staffing level and the quality care relatively positive. For example, 70% of them thought they had enough RNs to provide quality patient care, which was greater than in the NHS Scotland survey (18%) in 2010 (Bacon and Birkbeck, 2010). A possible explanation of this difference could be that this study was conducted in critical care settings. The positive perception toward their staffing levels might be an explanation that most RNs perceived their quality of care as staying the same or improved (6.1.3) as there was evidence supporting a relationship between nurse staffing levels and the quality of nursing care (Aiken et al., 2011) (2.3.6). However, nearly half Scottish RNs reported their staffing level over the last 12 month in their ward as decreased (6.1.3), and more than half of Scottish RNs in this study reported increased stress, workload and responsibilities (6.1.3). Similar results can be found in the NHS Scotland survey that 90% of RNs and RMs had unrealistic time pressure at their work (Bacon and Birkbeck, 2010). In this study, RNs felt their ward had enough staff to provide quality care even though they experienced decreased staffing levels, increased stress, workload and responsibilities. These findings would suggest that Scottish RNs believed they were delivering quality care within the limited resources and the environment where there were various changes that affected their workload and their role.

Summary

The third research question for the Scottish arm was answered fully. The responses to policies related to RQNs varied. Some perceived FS and ECCFs as support, but some expressed their doubt in the content of FS.

In the next section, responses to Japanese policies related to RQNs are discussed.

7.3.4 The Responses to Japanese Policies related to RQNs (research questions 3)

There were two major Japanese policies related to RQNs. The responses to these policies were investigated by the interviews and the questionnaire. The questionnaire provided general views of changes in the workplace and the nursing practice environment and the interviews provided perceptions and understanding of policies related to RQNs

Perception and Impact of Legislative Change in the Medical Care Fee Schedule in 2006 (2.7.7)

The Medical Care Fee Schedule was revised in 2006 and the government's intention for these changes was to improve the quality of nursing care by encouraging the employers to employ more RNs. As mentioned in the previous section (7.3.3), Fulop et al (2012) argued that how changes are perceived among stakeholders influences the process and the result of implementation (Fulop et al., 2012). Additionally, the features of changes are important as the implementation process is affected by the extent to which policy diverge from the previous policies and by the amount of organisational change that is required (2.9) (Van Meter and Van Horn, 1975). This legislative change was perceived as a good financial opportunity to claim the maximum remuneration for hospital managers (JNA, 2007c) (2.7.7 and 5.7.2). This initiative was implemented broadly and made a huge impact on clinical practice (JNA, 2007c) and this was probably because the change was perceived as a good opportunity among hospital managers as argued in the literature (2.9)

The most common perceived outcome of legislative change was the increased number of RNs in the hospitals. 'Number and Quality of Nurses' (5.6.2 and 5.7.2) described the impact of this legislative change. This perceived change in numbers of RNs was also seen among RNs ('Staffing and Resource Adequacy' 6.2.4). The PES-NWI shows that more than half of Japanese RNs in this study agreed that they had enough staff to get the work

done and nearly half agreed they had enough RNs to provide quality patient care. These results showed much better figures than the similar study conducted by Kanai-Pak et al (2008) in a Japanese acute care university hospital because the data for Kanai-Pak et al's study was collected in 2005, before the change. However, the change over the 12 months regarding staffing level (POWCS) in this study did not match the change by legislative change in 2006. The POWCS showed that 40.6% of RNs reported staffing levels had decreased. Additionally, more than half of RNs thought they did not have enough RNs to provide quality nursing care (6.2.4). There are two possible explanations for this disparity. Firstly, there may have been a gradual change in the staffing levels over the last few years to adjust the inappropriate allocation of RNs within hospitals that happened at the time of legislative change. However, no data available to know if this is the case. Some managers expressed their concern about the allocation of RNs employed to gain the 7:1 approval as nurses were not necessarily allocated to the places where nurses were really needed ('Impact of 7:1 Patient Nurse Ratio', 5.6.2), and reported in the Japanese Association survey and media (JNA, 2007c; Toyokeizai Newspaper, 2008). Secondly, this study was conducted in critical care units where usually the staffing levels are different from other wards. Thus, this might have caused the disparity of their perception of changes in staffing levels. Yet, there might be some other issues related to nursing workforce in Japan that are not revealed in this study.

As a result of having employed more RNs for 7:1 approval, a change in the workload per RN was also perceived. Ward managers experienced an improvement of the workload per RNs, as reported in 5.7.2 and 5.8.2. On the other hand, RNs perceived the change related to workload differently (6.2.3). Even though more than half of the Japanese RNs reported that they had enough RNs to get their work done (6.2.4), more than half Japanese RNs thought their workload had increased over the last 12 months as well as their stress levels (6.2.3). One of the possible reasons for the increased workload among RNs could be explained by how the hospital met the criteria for the approval. Employing newly registered nurses was a common strategy, but this demanded the educating and mentoring of RQNs increased and this could be a possible explanation as to why Japanese RNs perceived their workload increased.

Responses to Legislative Change in 'Public Health Nurses, Midwives, and Nurses Act' in 2009 (2.7.7)

New regulation was introduced in 2009 to promote high quality nursing care to meet the demands of the healthcare service due to the demographic changes in the Japanese population (MHLW 2009b). The new regulation required RQNs to seek the opportunity to attend any continuous training courses after registration, and for hospitals to establish a clinical training system for RQNs and to provide RNs with the opportunities to attend any training course. No specific impact of this legislative change was reported in this study. However, potential outcomes of this change could be found in some themes related to their expectation of this legislative change (5.7.3 and 5.8.3). Most managers had positive expectations that this change might provide all RQNs with a foundation of clinical nursing skills and knowledge to fill the gap between pre-registration and clinical practice. This expectation is similar to the expectation of FS among Scottish managers (5.3.2 and 5.4.2). The lack of clinical nursing skills was reported by RQNs in the JNA survey (JNA, 2004b), as well as theory-practice gap perceived by managers among RQNs from this study ('Expectation/Experience Gap' in 5.8.1). As discussed (2.4.3), rapid turnover was one of the key issues related to RQNs and dissatisfaction with their ward assignment was identified as a risk factor to turnover (Suzuki et al., 2006). Managers in this study expected that the orientation training system would improve the retention of RQNs, as well as improving the quality of nursing care, by providing RQNs various experiences in many wards. Thus, orientation training system may help to reduce the dissatisfaction of the ward assignment among RQNs and resulting in retention of RQNs. In contrast, the lack of staffing was identified as an issue and a key factor in achieving the goal of government policy. As discussed in the previous sections (2.7.7 and 7.2.3), gaining and maintaining the 7:1 ratio approval was challenging for some hospitals.

Perceptions of Japanese Nursing Workforce Planning among Nurse Managers

Similar to Scottish managers, general responses to Japanese nursing workforce policies among nurse managers also varied (5.7.1 and 5.10.2). Interestingly, nurse managers and ward managers both had negative perceptions of the government policies (5.7.1 and 5.8.1). However, the negative perceptions among nurse managers were more related to the content of policies whereas ward managers' perceptions were related to how policy was implemented. For example, nurse managers appreciated the government intention to improve the quality of care by introducing incentives, but also criticised the government

for not working on the issues, e.g. which is nursing work environment, and focusing only on providing a stable inflow of new graduates. On the other hand, ward managers perceived that government policies were not implemented in the ward level (5.8.1). The different perceptions between managers are understandable as they have different roles and views related to policies. However, the difference may have been a reflection of the Japanese policy structure, which focus on hospital management rather than clinical nursing practice.

Summary

The third research question for Japanese arm was answered with various aspects of different interview groups. Interviews with managers revealed outcomes of the legislative change related to their clinical practice, especially the number of RNs, and identified issues related to experienced nurses and RQNs. The findings of the interviews answered this research question and the results of the questionnaire provided additional understanding of responses to these policies.

7.3.5 Issues and Concerns related to Scottish Policies (Research Question 4)

Several concerns and issues were shared among managers and RQNs in relation to Scottish policies. These concerns and issues were explored mostly by the interviews with managers and RQNs.

Issues and Concerns related to FS

As discussed in the previous section, some aspects of FS were perceived negatively. Firstly, the structure of FS made completion of FS difficult and confusing as FS had too much flexibility and vagueness (5.5.2). RQNs were expected to ‘self-direct study’ for FS and spend 150-200 hours to complete (NES, 2006). However, RQNs had no way of knowing if they were meeting the right standard as the criteria for completing FS was too vague and flexible. Even for the government, there is no monitoring system how many RQNs have completed or not. Mazmanian and Sabatier (1980) argue that a structured implementation process and support from related groups are important in terms of effective implementation (2.9). Therefore, in order to implement FS, standard criteria for completing FS and guidance in terms of completing FS are needed.

The second issue identified by RQNs was lack of understanding of other members of staff (5.5.2). The level of understanding of FS highlighted a gap between managers' and RQNs' perceptions how well/ or not FS was implemented in clinical settings. Among nurse managers, the views toward awareness of FS varied. Some thought that FS was well implemented and well known as most senior charge nurses and RQNs knew about it, whereas some identified RQNs did not have enough understanding of the benefit of FS (5.3.3). RQNs' view towards awareness and understanding of FS among other member of staff was different from managers. The results from the questionnaires showed that only 1.9% of RNs reported that they had never heard of FS (6.1.2) However, RQNs thought that the awareness of FS was not well established among senior charge nurses and other members of staff because they did not get enough support for completing FS. Lack of awareness and understanding left RQNs to complete FS without support.

These two aspects, the vagueness of FS and lack of support from others could be why RQNs found it difficult to engage with FS (5.4.2). Similar issues were also recognised in the evaluation study by Banks et al (2010). Again, the importance of stakeholders, in this case other staff nurses, was highlighted in this study in order to implement FS in clinical practice.

Issues related to ECCFs

RQNs and managers had some concerns related to ECCFs. The issue shared by nurse managers and RQNs was resentment from other staff. For example, fellows were seen as the elite by senior charge nurses and other member of staff. Staff nurses seemed to be resentful about the benefits given to the fellows and some senior nurse managers understood that ECCFs were career boost (5.4.2). Perhaps, this should not be a surprise because, as stated (2.5.7), there are four steps to go through to be involved in ECCFs and the fellows were carefully targeted and chosen. Additionally, they had not only financial support, but also clinical support. Even though NHS nurse managers and ward managers perceived the fellows as motivated, enthusiastic, and committed (5.2.2 and 5.3.2), there was a risk that the inappropriate understanding of ECCFs among other staff may have impacted negatively on the fellows' experience of ECCFs. Fortunately, RQNs did not have negative perception of ECCFs even though they had some concerns about the lack of understanding of ECCFs. ECCFs was perceived as a great opportunity (5.5.2). These findings may highlight the need for the government to provide similar opportunities for other staff nurses as well as ECCFs.

Pearson and Machin (2010) suggest that there is a need for NHS Scotland to establish career guidelines or pathways for these fellows so that the investment in these fellows could be evaluated and monitored. In this study, similar concern emerged. Despite the government's intention to nourish leadership in nursing through ECCFs, vagueness of future pathways for fellows was identified by nurse managers (5.3.3). Some managers expected them to stay (5.2.2) to make the maximum of the initiatives on clinical practice. However, there was no clear message or regulation in ECCFs that these fellows were expected to stay in clinical practice. Some fellows in this study had already decided to move into an academic role. Pearson and Machin (2010) identified that most fellows saw themselves in their clinical role only for a short period (2 years), but half the fellows expected to be in a management role and a quarter of them hoped to be in another role in 10 years' time (Pearson and Machin, 2010). However, there were no guidelines or pathways for these fellows after their completion. The findings from this study highlighted the need of establishing a monitoring system for these fellows after completion of ECCFs as well as career pathway so that the government investment could be traced and evaluated.

Issues and Concerns related to Scottish Nursing Workforce Policies

Maben et al (2006) revealed that there is theory-practice gap among UK RQN. In this study, ward managers experienced differences in RQNs' profile (5.4.3) as a result of change in pre-registration education. As mentioned in the literature review (2.4.2), 'Project 2000' (1989) reformed the nursing education system dramatically. Ward managers' responses to the change in RQNs' profile were not favourable and ward managers seemed to have some concerns about the change in RQNs profile and how they have been educated to be a nurse. They thought the right candidates for nursing were not being selected. These concerns emerged from a change in RQNs' profile as well as from a shift in pre-registration education between generations, ward managers and RQNs.

Summary

The fourth research question for Scottish arm was answered. . Interviews with managers and RQNs revealed issues related to FS and ECCFs as responses to the initiatives.

7.3.6 Issues and Concerns related to Japanese Policies (Research Question 4)

Several concerns and issues were shared among managers and RQNs in relation to Japanese policies. These concerns and issues were explored mostly by the interviews with managers and RQNs.

Issues and Concerns related to Legislative Change in the Medical Care Fee Schedule in 2006

As a result of employing many RQNs for 7:1 approval, three major concerns emerged; 1) the quality of nursing care, 2) the workload involved in educating RQNs, 3) the ability of experienced nurses. These concerns were seen in several categories (5.7.2 and 5.8.2).

Firstly, some managers had a doubt about the quality of nursing care and some said it had actually decreased (5.7.2 and 5.8.2). Despite this, the quality of nursing care might have been improved gradually over the years. For example, nearly half Japanese RNs thought that their quality of nursing care had improved over the last 12 months (6.2.3) and that they had enough RNs to provide quality patient care. However, it is difficult to suggest something from these findings as they are subjective. Additionally, there was no indicator or evaluation system to measure the impact of legislative change.

Secondly, the concern in the ability of experienced nurses as a clinical educator along with the workload of experienced nurses to educate RQNs emerged as issues among nurse and ward managers (6.8.2). The heavy workload of educating RQNs might have had caused by a lack of adequate staffing, lack of support for experienced nurses and usual general nursing practice, in addition to the increased number of inexperienced RQNs employed due to the legislative change. The heavy workload of preceptor was recognised also by O’Kane (2012).

Ability and Characteristics of RQNs

In addition to the key issues related to RQNs described in the literature (2.4.3) such as the theory-practice gap (Maben et al., 2006; Mooney, 2007), managers had concerns about the ability and characteristics of RQNs. These concerns were not directly related to the policies discussed above (7.3.4), but describe the broader issues and concerns related to the

Japanese recently qualified nursing workforce. Two major changes within RQNs were perceived: lack of commitment to their profession and their social skills.

RQNs' commitment to their career choices can be seen in some themes where some RQNs did not have a clear view or preference as to where they would like to start their career (5.9.1), and how they would like to develop their career in nursing. Two factors may have affected RQNs' commitment to their profession. First their social background such as life style and the compulsory education system over the last few decades. It could be argued that economic growth over the last few decades (World Bank, 2009) and Japanese post-marriage life style (2.7.8). The second factor affecting their professional commitment may have been the employment system in the hospital. As mentioned before (7.3.2), RNs in Japan are employed by each hospital and are not always able to make decisions on which area they would like to work in. However, as the current economic situation and demographic changes there might force RQNs to work longer in clinical nursing practice.

The other change reported in RQNs' characteristics were their social skills. The Japanese Nursing Association Survey (2004) found that communication with patients and the relationship with peers were key factors for the transition process. Additionally, Nagata et al (2006) suggested that the relationship with their peers could improve the experience of RQNs' transition (2.4.3). In this study, the findings support previous studies (JNA, 2004b; Nagata et al., 2005). The relationship with other members of staff was found to be affecting their transition process (5.9.1). Some RQNs found their peers to be supportive and helpful, but some found it stressful. Some managers found RQNs having difficulties communicating with others, including patients, family and other members of staff (5.7.3 and 5.8.3). Establishing a good relationship with peers could be very challenging, especially for young RQNs in Japan. In Japanese society, order and social position are valued and you need to show your respect to your superior (Sugiura and Gillespie, 2006) (2.7.8). This Japanese culture might have added an extra challenge for RQNs during transition when establishing a good relationship with other members of staff who are older and more experienced than the RQNs. This could be the reason why managers perceived RQNs' social skills were not as well as they could be.

In this section, a few changes in RQNs' characteristics and how these changes were perceived by managers were discussed. Managers perceived these changes as an impact of social status and economic change over the last few decades. However, these changes and

perception could be just a cultural difference between an older and younger generation of nurses.

Issues related to Japanese Nursing Workforce Policies

Japanese managers were aware of several issues in the Japanese nursing and healthcare system in relation to the outcomes of policies related to clinical nursing practice. One was the lack of an integrated government approach towards nursing workforce planning in Japan, and the other was a lack of a standard monitoring system for the nursing workforce.

The Japanese government took initiatives for each issue related to nursing workforce and published many reports based on meetings and public hearings (MHLW, 2004c; MHLW, 2005b) (2.7.7). However, there were no policies or documents that provided a big picture as to how the government was to tackle the issues broadly. Even with a policy, sometimes it was just too vague (MHLW, 2008). Lack of an integrated government approach could cause conflict between government initiatives in the hospital level. For example, the government attempt to improve the quality of RQNs (MHLW, 2009c) could conflict with legislative change in 2006 (Central Social Insurance Medical Care Committee, 2005). The government advised hospitals to make efforts to establish an orientation training system for RQNs (2.7.7), which required hospitals to secure additional RNs to support RQNs. However, these RNs and RQNs were usually counted in the patient-nurse ratio. Therefore, in most of the cases, it was left to the individual hospitals and individuals themselves to improve the situation in healthcare service, such as the shortage of nursing staff, the quality of nursing care and nursing education. Even though the managers had positive perceptions towards the government's recent attempts and approaches, doubt in the sustainability of change due to the lack of resources and contradictive approach were reported (5.6.1).

As several documents argued before (MHLW, 2005b, JNA, 2007a), there is a flaw in Japanese nursing workforce planning. The necessity of establishing a system to monitor the number of RNs was identified (5.7.1) as well as Buchan (2006) highlighted the importance of establishing a system to monitor the demand and supply of nursing workforce. Even though the Japanese government publishes a forecast of the nursing supply and demand (MHLW, 2005a; MHLW, 2010c; MHLW, 2010a), lack of a standard measurement tool for nursing workforce remained as an issue. Currently, it is estimated that there are more than 500,000 Japanese RNs who are not working. Discussions about nursing workforce planning are based on estimated numbers as there are no reliable data

for the number in the potential nursing workforce. Thus, there is an urgent need for the Japanese government to establish an accurate monitoring system for nursing workforce in-out flows.

Summary

The fourth research question for Japanese arm was answered. Interviews with managers and RQNs revealed issues related to legislative change, such as quality of nursing care and the increased workload for RNs, as responses to the initiatives.

7.3.7 How Policies related to Recently Qualified Nurses can be Better Developed and Implemented (Research Question 5)

The responses to the government policies related to RQNs and concerns and issues were discussed above. The government approaches towards RQNs in Scotland and Japan are different and it is difficult to suggest which approach is better than the other because the nursing workforce is complex. There is no magic solution for the issues. Government attempts in both countries are real attempts to improve the healthcare service. However, there are several suggestions that could improve for better policy development and implementation

Suggestions for Scottish and Japanese Government

Several suggestions could be applied for both countries in terms of development and implementation of policies. There are small differences in details, but the Scottish and Japanese governments have similar issues that need to be improved or changed.

First of all, the Scottish and Japanese government need to establish a standard monitoring or evaluating system for government initiatives. As discussed (7.3.5 and 7.3.6), the lack of a monitoring and tracking system in FS and ECCFs was highlighted as an issue by interviews and the literature review (2.6.7, 5.3.3 and 5.4.2). In addition to the lack of a monitoring system for the number of Japanese RNs such as a registration system, lack of evaluation for government initiatives was also identified. Without evaluation of the initiatives and tracking the changes and outcomes, it is difficult to expect that government policy objectives can be achieved and sustained over time.

Secondary, it is important to develop and implement a nursing workforce policy, which does not cause large fluctuations of staff, particularly in Japan. As discussed (7.3.4 and 7.3.6), there was a large annual influx of Japanese RQNs and inappropriate allocation of RNs, which was caused by the government initiatives that affected other members of staff. In this study, such a Scottish policy that caused large fluctuations for the last couple of years was not identified.

Thirdly, there is a need to develop more integrated nursing workforce policies in order to tackle complex issues related to nursing workforce planning (7.3.6). Japanese managers were aware of nursing work environment needs to be improved in order to secure a sufficient number of RNs and quality of care (5.7.1). However, there were no policies that cover all aspect of nursing work environment and some policies conflicted each other at the ward level (5.7.1) (MHLW, 2003c; MHLW, 2008; MHLW, 2011a).

Lastly, the Scottish and Japanese governments need to sustain the good attempt to improve the healthcare service and sustain the changes brought by previous policies. In order to sustain the good attempts and changes, the government needs to communicate with the public and deliver the healthcare service, which reflects public needs, within the limited resources (MHLW, 2003c; Scottish Executive, 2005b; Scottish Executive, 2006a; MHLW, 2008).

Suggestions for Scottish and Japanese at the Operational Level

At the operational level, suggestions based on the interviews with managers and RQNs regarding policy development and implementation follow.

An individual's motivation and commitment are identified as important features in effective implementation (Elmore, 1978). In Scotland, lack of engagement among RNs and RQNs was identified as an issue. Ensuring engagement from RNs for the initiatives is important in order to develop and implement policy effectively (Elmore, 1978). As discussed (7.3.5), inappropriate and insufficient understanding of initiatives resulted in some difficulties for implementing initiatives (2.9). Even though, managers seemed to understand the policy drivers and background, there might be some approaches for RNs that the government could use to maximise the involvement of RNs in the policy developing process as well as implementing process. For example, in order to increase the engagement among Scottish RQNs with FS, FS could be combined with ward-based

competency books by adapting the contents to be more related to daily clinical practice. Another example for increasing the awareness and understanding of initiatives among RNs, study days could be organised targeted at not only RQNs, but also other staff nurses to learn about FS and ECCFs.

In Japan, lack of funding and resources were identified as issues in terms of implementing government initiatives (5.7.1, 5.7.2, 5.8., and 5.8.2). It is crucial to ensuring funding and resources when implementing policies (Van Meter and Van Horn, 1975). However, Japanese nurses experienced difficulties to sustain changes due to the lack of resources (including funding and human resources). In particular, the lack of preparation of experienced nurses to act as mentors to RQN and over workload as a clinical educator (5.7.2 and 5.8.2) became an issue. Experienced nurses did not have spare time to educate RQNs and the ability to mentor RQNs.

As discussed above, not only RQNs but also experienced nurses seemed to be key factor at the operational level in terms of implementing government initiatives for RQNs. In this study, the findings highlighted that experienced nurses also need to be supported and considered as a key factor in the policy implementation process, even though the government initiatives are particularly targeted at RQNs.

7.3.8 Summary

In this section, the findings from the interviews and the results from the questionnaires were discussed together in order to answer the research questions. The government policies related to recently qualified nurses were identified in both countries and compared. Responses to these policies and issues at the operational level were discussed separately in Scotland and Japan.

7.4 What did This Study add to the field of Knowledge

Several findings of this study add new aspects to the existing knowledge in terms of policies related to RQNs and their outcomes in the wards.

- More Scottish RNs were aware of nursing workforce policies and their impact on clinical practice compared to Japanese RNs.

- There is a misfit between government intention and actual outcomes in Scotland and Japan regarding recently qualified nursing workforce policies.
- Scottish managers and RQNs identified some positive outcomes of the policies of FS and ECCFs that are expected as well as some issues related to implementation such as lack of understanding (5.3.3).
- In Scotland, one of the issues and concerns related to policy implementation in clinical practice is engaging RNs with policies. Lack of understanding among stakeholders was a key issue in both initiatives, FS and ECCFs. This resulted in other issues, such as lack of support from other members of staff for the programmes (5.3.3 and 7.3.5)
- Japanese managers experienced an increased number of RNs in the hospitals, but they had doubts as to if the quality of nursing care was improved, which was meant to be the government objective (5.7.2 and 5.8.2).
- In Japan, issues related to policy implementing are about resources (including staffing) and funding. One of the key issues identified among Japanese managers was the quality of experienced nurses who are in charge of educating RQNs. There was doubt as to the quality and ability of experienced nurses to mentor newly graduated nurses (5.7.2 and 5.8.2) as well as the concern regarding their workload (7.3.6)
- RNs' participatory role in hospital policy decisions and governance were similar between Scotland and Japan, but Japanese nurses had more opportunity to serve on nursing and hospital committees (6.3.2 and 6.2.4).
- In both countries, RNs reported increased level of stress, workload, and responsibilities when more Scottish RNs reported that their morale has decreased compare to Japanese RNs.

7.5 Methodological Issues

Several issues regarding the research methods are discussed in the following section; the appraisal of applying a case study approach, study rigour, translation and conducting a two-single case study in different countries.

7.5.1 Case Study as an Approach

The challenges of this study were; 1) developing, adapting and translating data collection tools, 2) conducting semi-structured interviews with people with various background, 3) comparing the findings and results from two single case study, Conducting two single-case studies was challenging for the following reasons:

Firstly, developing, adapting, and translating data collection tools for this study required some time and dedication because there were two different interview guides and a questionnaire, composed from two adapted tools (POWCS and PES-NWI) in two languages.

Secondly, conducting semi-structured interviews with key people from various groups and managing the amount of collected data was time consuming and challenging as the researcher had no previous experience conducting interviews with health professionals.

Comparing the findings from the two single-case studies and comparing the findings from the different participant groups within the same country was highlighted as the third challenge. The comparison of findings was particularly challenging due to the volume of data and the variation of comparison. After discussion with the supervisor, comparisons between nurse managers and ward managers within the same country and comparisons between countries within the same interview groups were made.

7.5.2 Mixed Methods and Data Triangulation

Linking the findings from the interviews and results from the questionnaire was challenging because they did not always match. As noted in 3.3, generally speaking, applying mixed methods strengthens the validity of the study and provides different aspects and understanding. Generally in this study, the results from the questionnaire supported the findings from the interviews and provided a general view and understanding of the nursing practice environment in each country. Not unexpectedly there were some

differences which then required careful consideration to link the findings and result in the context of this study setting.

7.5.3 Missing data in the Questionnaires

In this study, all missing data was excluded from the statistical analysis based on the statistical advice (4.4.9). During the questionnaire data analysis, the researcher realised there was a trend in missing data in Scotland and Japan, in particular related to the POWCS and PES-NWI (Nursing Participation in Hospital Affairs). The most reasonable explanation would be the structure of the questionnaire. The questionnaire was printed on both sides. Additionally, the participants might have not followed the right path to answer the questionnaire because the filter for RNs was based on their length of experience at the beginning of the questionnaire (Appendix x). Japanese RNs might have chosen not to answer some questions because they did not know enough about the topic, or they felt uncomfortable because it might cause some tension within the group by standing out from the crowd.

7.5.4 Translation

In this study, there were two different occasions when the researcher needed to translate: translating the research documents and data collection tools which required back-translation, and translating the findings and the quotes from Part 2 of the study (4.5.1 and 4.5.9). The major challenge emerged during translating Japanese quotes from the interviews. The researcher felt she was involved in the interview data too much and had almost lost an objective perspective. That resulted in difficulties in capturing the meaning of the original quote and preserving the original impression of the quote. After discussion with the supervisor and some advice on the choice of vocabulary, the translation was improved and the researcher was able to keep the meaning of the original quote and impression.

7.5.5 Challenge of Cross Cultural Study

One of the main challenges was to manage the amount of data from two countries gathered by interviews (4.4.7). During organising the interview data from Scotland, a longer time was needed to transcribe for each interview, but a shorter time was needed to capture the key topic and to understand the meaning of the context. With the Japanese interview data,

obviously a shorter time was needed to transcribe, but it took a longer time to make sense of the interview context. The researcher realised it was not because of the structure of the Japanese language, rather the content of each of the interviews.

Another challenge was to manage the two studies in different countries within the limited timeframes. At the planning stage of this study, the researcher and the supervisor had discussions several times on how to manage the two case studies in different countries within the limited timeframes. (4.3). In this way, the researcher was able to develop several research skills and familiarise herself with the data collection process in Scotland as she had previous experience of conducting a study with NHS RNs for her Master's degree.

The last challenge was the cultural barrier between Scotland and Japan. As described, there are differences in organisational structure and the two healthcare systems (2.5.4 and 2.6.4). The biggest difference in both countries was the process of getting ethics and access approval to the study site. In Scotland, there was a clear path to follow in order to gain the approvals for this study in Scotland. However it was not easy for the researcher to find out the appropriate pathway to follow in order to gain the approvals in Japan. The researcher experienced a little cultural shock in gaining research approval in the Japanese study hospitals, which was not expected to happen in her home country.

7.6 Study Rigour

Establishing rigour is crucial to ensure the findings of studies are robust and reflect the true state of phenomena. In this study, the literature review was conducted systematically, and all research processes were conducted and documented to strengthen rigour of this study. In this section, how the four criteria of study rigour were strengthened is presented.

7.6.1 Credibility

Credibility indicates the degree of truthfulness of the data and data interpretations (Polit and Beck, 2004). To enhance the credibility of the data and interpretations, a couple of techniques were applied in this study: prolonged engagement and triangulation. As result of data triangulation, comparisons were made between different groups within the same country (5.9.1 and 5.9.2), and they provided different aspects and understanding with diverse information. Additionally, methodological triangulation, data from different

sources, such as interviews and the questionnaires (POWCS and NES-NWI), produced diverse information.

7.6.2 Dependability

Dependability is a similar concept to stability and is parallel to reliability in quantitative research (Polit and Beck, 2004). Several strategies were applied in this study to increase dependability (3.10.2). Throughout this study, the researcher was the only person who was involved in the data collection and analysis. Thus, the quality of collected data from the interviews remained constant. Furthermore, the inquiry audit technique was applied (3.10.2). For example, themes and categories were reorganised after several discussions with the supervisor and the researcher's colleagues (4.4.8).

7.6.3 Confirmability

To enhance the neutrality of the data, several strategies were applied in this study (3.10.3). During the whole study process, especially data analysis, the researcher and supervisor had regular discussions regarding interpreting the data from Scotland and Japan. Additionally, several discussions were held regarding the data from Japan with the mentor in Japan. By these discussions, the researcher was able to reduce any bias and produce compatible interpretation of the data. For example, the supervisor with the Western background was able to provide different aspects of the cultural differences between Scotland and Japan. Thus, the researcher benefited from these different aspects on her reflection of the research process (7.8.1 and 7.8.2).

7.6.4 Transferability

There was an attempt to provide enough information regarding this study design, such as sampling, data collection, data analysis and the translation process so that the possibility of transferability can be judged. In addition to the study design, the background of each country (2.5 and 2.6) was provided, and the findings of this study were interpreted. There is a possibility of transferring the findings from this study to other, similar studies. However, the nature of the case study approach and the study settings should be considered carefully (Yin, 2009).

7.6.5 Summary

In this section, issues and challenges related to methodology were discussed. The usage of case study research and mixed method approach was reviewed. Translation was discussed as it was one of the most crucial processes in this study in order to collect the data and present the findings. Lastly, the study rigour was examined with several aspects, which allow the reader to judge robustness.

7.7 Reflections on the Research Process

The researcher kept researcher's notes during the whole process of study and field notes (3.6.5, 4.4.7, and 4.5.8) during the interview process. Based on these notes, several issues are discussed in the following sections.

7.7.1 Conducting a study in two countries

It is difficult, and not appropriate, to simply compare study participants from two countries by their job title, the environment, and other relating factors to their nursing practice as they vary in their healthcare systems, culture and educational background. However, the researcher perceived the differences and had a unique experience with the healthcare system and the participants in the two countries. These perceptions are anecdotal and thus there is no evidence to support the researcher's view. However, it might provide insight into the healthcare of the two countries.

First of all, the atmosphere of the critical care units was very different. The researcher felt the critical care units in Scotland were very quiet compared to the critical care units in Japan. This could be because of the larger size of the Japanese critical care units, the bigger number of beds, patients, other health professionals, the medical machinery in the critical care units, and the researcher's experience in Japan. After taking these factors into the consideration, the researcher still felt uncomfortable in Scotland. This could be a reflection of the researcher's feeling as the researcher was not very familiar with the Scottish healthcare settings.

Secondly, the Scottish recently qualified nurses seemed more confident and relaxed during the interviews. The possible reason why the researcher felt this is because of the Scottish government initiatives (2.5.7). It made some impact on their attitude and confidence. The

older age profile of Scottish RNs might have some impact on the age of the first entry to nursing (2.5.6). However, a more reasonable explanation could be the relationship between the researcher and the participants in Japan, which is discussed later on this section (7.7.4), but which was complicated.

Lastly, the vocabulary of the managers, in particular the ward managers, used in the interviews was different. The researcher felt there was more jargon related to policy and management with Scottish ward managers, whereas Japanese ward managers seldom use professional jargon. This could simply be the difference of language. However, this also could mean that Japanese ward managers deliberately did not use jargon as some of them knew that the researcher did not have experience as a ward manager or they simply did not use these words that often.

These differences that the researcher experienced make it difficult to discuss, as the healthcare environment in each country is complex and not able to be examined that easily. However, the researcher thought this experience was very unique and precious, being able to conduct a study in a two different countries where the researcher was heavily involved as both interviewer and administrator.

7.7.2 Conducting Interviews with Managers

The researcher experienced several differences between Scotland and Japan interviewing managers. Generally, Scottish managers seemed to be familiar with the opportunity to talk about policies and their view towards policies related to RQNs. On the other hand, the responses of Japanese managers to the interview questions varied greatly. Some Japanese managers were eager to discuss several issues related to nursing workforce policies in Japan and were interested in the nursing workforce policies and issues in Scotland. However, some seemed to be focused on only the issues that affected their ward and hospitals and some had no interest in the broader view of nursing workforce policies in Japan.

7.7.3 The options of conducting a study in a general ward

The researcher was aware of the limitations of the results of this study within critical care settings as the study sites (ICUs and HDUs) were different from other wards in terms of staffing, ward function and structure, patients' characteristics, work environment, and

RNs' characteristics. In much of the literature presented previously, some of the studies (Numata et al., 2006; Stone et al., 2007a; Cho et al., 2009; O'Kane, 2012) were conducted in ICUs or with RNs working in ICUs because of the unique characteristics of the environment's RNs. On the other hand, some studies excluded ICUs because of the unique characteristics (Lang et al., 2004). In this study, the researcher was aware of the characteristics of critical care settings and the possible limitations for generalisation of the results. A case study approach was chosen in this study to gain a homogeneous understanding of two countries in terms of the impact of government policies related to RQNs, not to generalise the findings of this study. Thus, consideration was given to the study setting in terms of the limitations caused by the characteristics of the critical care settings, but the particular focus or justification was not made to the choice of critical care settings.

7.7.4 The relationship between the researcher and the participants

In this study, one of the study sites in Japan was where the researcher used to work several years back before this study took place (4.5.2). This benefited the researcher in several ways. Firstly, the researcher had knowledge of the hospital structure and how the study ward worked. It was easy for her to find the best way to approach and process the recruitment. Secondly, the researcher felt accepted and welcomed by the people in the study sites as the researcher was known by some ward managers and staff nurses. It was a positive factor for the researcher to establish good relationships with the ward manager and other staff nurses during the recruitment process. Finally, it provided a vivid image of the interview contents, as some of the topics the participants discussed in the interviews were familiar to the researcher as she had also experienced the situation the interviewee talked about.

However, there was a negative side, as some people in the study site knew the researcher before the study and so the researcher felt some RQNs were extremely nervous and polite to the researcher. In Japan, as a result of the feudal system in history (Sugiura and Gillespie, 2006), being polite to other people is a culturally common behaviour, and usually a difference in age and length of experience in the professional field are very important as people pay great attention to how people behave and talk to each other in such occasion. The researcher thought that some current staff nurses, who were senior nurses for RQNs, knowing the researcher as their senior nurse might have made RQNs uncomfortable and nervous.

The relationship between the researcher and the participants might have made an impact on the length of the interviews in both countries. As can be seen (4.4.7 and 4.5.8), the length of the interviews were relatively longer with Japanese participants than Scottish participants, even though the researcher used almost the same interview schedule. However, the Japanese findings of the interviews were smaller than Scottish findings. The possible explanations for the difference in the interview length and the depth of findings are as follows: firstly, Japanese was the researcher's native language so the researcher was able to conduct interviews more effectively and was able to probe the interviewees. In addition, the researcher felt that Japanese managers had lots more to say about the interview topics. However, the researcher felt it more difficult to manipulate the interviews with Japanese managers because of the relationship with the participants. Due to the Japanese culture (2.7.8), the researcher hesitated to interrupt the conversation when the participants were talking.

As noted earlier, the researcher experienced several differences between Scotland and Japan in terms of conducting a study: these were, for example, the cultural, organisational and healthcare system differences. Interestingly, the researcher experienced a cultural shock at the beginning of the study process when she returned to her home country and tried to gain access and ethics approval from the Directors of Nursing in the Japanese hospitals (4.5.2 and 4.5.3). Even though Japan is the researcher's home country and the researcher had experience of working in the Japanese hospitals for couple of years, this was almost her first experience in conducting a study in the Japanese hospitals from scratch. Thus, the researcher had some difficulties in adapting to the culture in Japanese hospitals in terms of conducting research there. For example, several steps were required to reach the right person to speak to and gain the official approval (4.5.2 and 4.5.3).

7.8 Study Limitations

The study limitations regarding study design, data collection, data analysis, language, and cultural differences are as follows:

- A case study approach allowed this study to explore the impact of the government policies related to recently qualified nurses and to be able to compare them between Scotland and Japan. However, the nature of case studies limits any generalisation (3.2.3). Therefore, this study is descriptive in nature.

- The study sites in both countries were in the critical care settings where the structure of the wards, staffing levels, and the working environment are very different to general wards, as some ward managers (5.4.2) and recently qualified nurses (5.5.1) commented. Additionally, the characteristics of the RNs working there may be different to the general population of RNs in clinical settings. Thus, a great deal of caution should be addressed as to the transferability of this study to other studies with different study settings.
- The idea of including the staff nurses who are involved in the government initiatives (FS and ECCFs) as RQNs' mentors emerged when the researcher started interviewing some participants. In Japan, the equivalent sample group of staff nurses who are involved as a RQNs' mentors would be staff nurses who are in charge of mentoring and teaching RQNs in the clinical settings. In this study, a purposive sampling method was chosen. It was possible to recruit these potential participants and create other sample groups. However, it was concluded this was not feasible during the limited timeframe. During that process, the researcher was eventually able to come across and include the participant who was also a mentor for FS who met the initial criteria for the Scottish interview and who used to be a mentor in the clinical settings recently in Japan. Purposive sampling enabled the researcher to include them for the interviews.
- In the Japanese arm of the study, despite the fact the researcher made some effort to recruit RQNs for the interviews, interview participants were only from one hospital. Even though they were from three different wards, this may have created some differences in the findings. It would have been useful if there had been RQNs from different hospitals to provide robust interview data.
- The definition of RQNs in this study resulted in excluding a number of potential participants who were RQNs in the year of legislative change in Japan (2.6.7) and RQNs who were involved in FS or ECCFs (2.5.7). Nevertheless, the researcher defined RQNs as registered for 24 months or less. Even though sufficient numbers were recruited within the timeframe, it could be argued that having a longer criteria for RQNs could have result in a better response and various other aspects over the several years when the policy changes were brought into clinical settings.

- Validated and reliable tools were adapted for the questionnaire and translated into Japanese. The back-translation was used where appropriate to enhance the reliability of the tools (4.5.1 and 4.5.8). However, there were several differences between Scottish and Japanese questionnaires as the researcher decided not to change the Japanese phrases where the Scottish version needed amendments in order to keep the original phrase of the Japanese version (Kanai-Pak, 2007; Kanai-Pak et al., 2008). Therefore, this may have affected the comparisons of results from the questionnaires and interpretation of the findings.
- The volume of missing data for the questionnaire among Japanese RNs was much bigger than Scottish in the POWCS as discussed in the previous section (8.4.3).
- The English language was a foreign language for the researcher. Translation was one of the biggest challenges in this study. A number of efforts were made in order to enhance the equivalence of meaning, for example, discussion and advice by the supervisor, especially when the researcher was translating the quotes from the interviews. However, it might still limit some of the impressions or expressions that are unique to the Japanese language when translating into English.

In the next chapter, the conclusion and recommendation of this study are presented.

Chapter 8: Conclusion and Recommendations

8.1 Introduction

In this chapter, the main findings of this study are summarised as well as presenting how this work has contributed to the existing body of knowledge. In the end, recommendations for each country and for further research are made.

The importance of nursing workforce in the current healthcare system was emphasised by the evidence that shows the relationship between nursing workforce and patient outcomes (2.3). Recent challenges in healthcare delivery caused by demographic changes and financial constraints are facing nurses who are the closest to the patient and the biggest professional group among healthcare providers in Scotland and Japan (2.5 and 2.6). Recently qualified nurses have become one of the key elements in nursing workforce in response to demographic changes and the recent trend of rapid turnover among Japanese RQNs as a result of the stressful environment at an early stage of career. In order to prepare and maintain the nursing workforce for the future need of healthcare, both countries have policies related to recently qualified nurses. Yet the comparison between Scotland and Japan and the impact of these policies and strategies are not well known.

Therefore, this study aimed to provide a broad understanding of the similarities and differences between Scotland and Japan regarding the nursing workforce planning policies targeted at recently qualified nurses and their influence on the critical care nursing wards. To achieve these purposes, a combination of quantitative and qualitative methods was applied including semi-structured interviews and questionnaires. Content analysis was used to guide the qualitative data analysis. In total, 21 managers and RQNs in Scotland and 19 managers and RQNs in Japan participated in the interviews, and 119 in Scotland and 83 in Japan, RNs participated in the questionnaire survey.

Similar key themes were revealed in the interviews with nurse managers and ward managers in Scotland. Firstly, 'Misfit between Policy and Practicality', emerged from nurse managers interviews, reflecting the gap among nurse managers between their expectations and understanding, and the actual experiences of the impact of policies, in particular FS and ECCFs. A similar theme emerged from ward managers, 'Expectations and Reality', that reflects the gap among ward managers in expectations of government initiatives and actual experience of them. Secondly, the themes emerged from participants'

perceptions and understanding of the government policies. Managers understood the policy drivers and their goals, and expected the changes that would be brought by the policy.

In Japan, the same key themes were shared among nurse managers and ward managers; 'Numbers and Quality of Nurses' and 'New Generation of Nurses'. 'Numbers and Quality of Nurses' refers to the outcome of legislative change with government intention of improving the quality of nursing care, including concerns and current issues related to this legislative change. 'New Generation of Nurses' reflect of managers' perceptions and understanding of RQNs who were employed at the time of legislative change.

In both Scotland and Japan, a similar concept in the outcome of government initiatives emerged; that is a misfit between policy intentions and the outcomes. This concept can be seen in the themes in each interview group.

8.2 Recommendations for Scotland

Based on the evidence of this study, the intention of the government initiatives targeted RQNs were perceived positively among managers and RQNs. In particular, ECCFs were perceived as a great opportunity for RQNS. However, there were some doubts and concerns in terms of embedding the policy and delivering the benefits of FS and ECCFs.

Therefore, for those who are involved in the programmes, practical recommendations are suggested as follows for each programme and the government approaches towards recently qualified nurses.

8.2.1 Recommendations for Clinical Practice in Scotland

In relation to FS

- Increase the awareness and understanding of Flying Start, not only among RQNs and Senior Charge Nurses, but also other members of staff who are supporting RQNs to complete FS (5.2.3) by following approaches; organising a study days of FS for all member of staff, allowing all staff members access to FS, involving other member of staff in the process of FS.
- Engage RQNs more in FS by the following approaches; combine FS and the ward based competency book to adapt the FS content more to the area of their practice

(5.2.3), allocate more study time to RQNs to complete FS, prolong the expected completion time from over 12 months to over 24 month (5.3).

- Create guidelines and criteria for completing FS so that the government can track numbers of RQNs who complete and RNs (Managers, mentors, and RQNs) have a better understanding of FS.

In relation to ECCFs

- Increase the awareness and understanding of the Early Clinical Fellowships among senior charge nurses and other members of staff (5.2.3) by; organising study days of ECCFs for staff nurses including senior charge nurses.
- Establish a career pathway that all staff nurses could follow or perceive benefits from, if they wanted.
- Provide career guidance or pathway for ECCFs fellows on the completion of ECCFs (5.2.3) so that the government could make maximum benefit of fellows.
- Establish a tracking system for these fellows after the completion so that the government can evaluate the outcomes fully.

In relation to Policies related to Nursing Workforce Policies

- Involve RNs, not only managers, but also other members of staff, in policy development and the implementing process in order to increase their engagement and improve the policy implementation process.
- Keep the attempt to improve the healthcare service and sustain the changes brought by the policy implementation.
- Ensure the evaluation for government initiatives is always in place.

8.3 Recommendations for Clinical Practice in Japan

Based on the evidence of this study, the government policies and legislative changes were perceived relatively positively among managers. In particular, legislative change in 2006 had made a great impact on the number of RNs in the ward. However, there were some doubts and concerns in relation to the increased number of recently qualified nurses in the wards.

Therefore, practical recommendations are suggested as follows.

In relation to Legislative Change in 2006 and 2009

- Establish a support system for experienced nurses to be a clinical educator for the annual influx of RQNs.
- Establish a standard indicator to measure the quality of nursing care to evaluate the outcome of the legislative change in 2006.
- Maintain the appropriate staffing allocation.

In relation to Policies related to Nursing Workforce Policies

- Establish a national system to manage the data regarding nursing workforce for more efficient planning policies such as introducing a registry system for nurses.
- Introduce more incentives through the medical care fee schedule revision that reflect patients and health providers' need rather than the managers and hospital owners.
- Allocate government funding and resources to nursing workforce planning especially to improve the work environment for nurses.
- Establish a standardised orientation training system to support experienced nurses in terms of their career development and their skills and knowledge of nursing education.

8.4 Recommendations for Nursing Education

Recommendations for nursing education based on this study's findings and process are;

- Increase the knowledge of policies related to clinical nursing practice. The findings from this study suggested that lack of understanding and engagement with policies among RNs can be an obstacle to implement the government initiatives. The findings of this study highlighted again the importance of nurses' involvement in policies.
- It should be noted in nursing education that consideration in the variation of culture, social system, and organisation is crucial when conducting a study internationally.

8.5 Recommendations for Further Research

For researchers who are interested in the study of policies and their impact in the nursing field, and in the study of international comparison, some recommendations for further studies are suggested.

- For researchers who intend to investigate the impact of policies in the clinical practice, using similar research approaches and measurement of nursing practice environment and workplace change are suggested so that the findings and results can be compared.
- Consider including a document content analysis for researchers who intend to compare and investigate government policies in different countries so that the comparison of policies can be verified.
- As an extension of the findings of this study, specific studies that include experienced nurses might be useful. This could help to provide different aspects of outcomes of government initiatives

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Appendices

Appendix I: Example of 'Facing the Future' Group updates on work progress



	FACING THE FUTURE
	Nursing and Midwifery Recruitment and Retention
Issue 3	November 2003

Welcome to the third in a series of newsletters designed for Nurses and Midwives, whether in training or in practice. These newsletters aim to keep you updated on the progress made on the various initiatives under the banner of *Facing the Future*.

What's in this newsletter?

- A Partnership for a Better Scotland: Partnership Agreement
- Nursing Workload – An update on the Nursing Workload Project
- 'New Nursing Roles – Deciding the Future for Scotland.' Information on the forthcoming Consensus Conference for Nurses
- Student Nurse Numbers
- New Website


The Partnership Agreement

As part of the discussions following the Scottish Parliament elections in May 2003, the Labour/Liberal Democrat coalition produced *A Partnership For A Better Scotland: Partnership Agreement* as part of its programme to deliver excellent public services in Scotland. This commits the Scottish Executive Health Department to step up action on health improvement, to improve the quality and consistency of care through national standards, inspection and support; and to improve the delivery of services. The *Partnership Agreement* also commits the Scottish Executive Health Department to

delivering improvements to NHSScotland through the empowerment of the workforce. Within the Partnership Agreement are a number of commitments which are specific to nurses and midwives. These are:

- 'We will increase our programme to train, recruit and retain nurses and midwives, bringing 12,000 into the NHS by 2007 as part of our overall improvements in workforce planning in the NHS.'
- 'We will treble existing numbers of Nurse Consultants to 54.'
- 'We will continue our guarantee of one year's employment for all newly qualified nurses and midwives.'
- 'We will implement nationally co-ordinated nursing bank arrangements to assist nurse placement across Scotland, to improve patient services and cut the costs of agency nursing.'

In support of these commitments, a number of initiatives are ongoing under the banner of *Facing the Future*. The following provides an update against these as well as other issues of interest.



One Year On

Mr Malcolm Chisholm, Minister for Health and Community Care, gave the opening address at the "Celebrating Best Practice" event on 19th November 2002 at Westpark Conference Centre, Dundee. There he took the opportunity to meet a number of nurses who had taken part in initiatives arising from the National Facing the Future Convention held in 2001. Speaking at the Event, Mr Chisholm said, "I am really pleased to be with you to open the conference on celebrating best practice. There is much to celebrate and value in what you do and the difference you make to patients and families."

Mr Chisholm went on to inform the delegates of the progress made under the banner of *Facing the Future*. "Since the first national convention on nursing recruitment and retention in November last year, we have provided additional funding of £1.5 million to create an extra 250 student nurse places this academic year."

"In July, we announced an additional £1.75 million for continuing professional development for nurses and midwives. This extra investment is already enabling staff to benefit from educational courses, which support the sharing of good practice, development of overall skills, increased opportunities for mentorship and effectively improve the overall standards of care offered to patients."

"Other developments this year include a £1 million investment announced last month to fund Return to Practice for nurses and midwives throughout NHS Scotland during the next two years. This is already encouraging staff who have left the service for personal or domestic reasons, to return to the NHS. We have also made available £380,000 in funding for the RCN Leadership Programme." The Minister also added, "As part of a commitment that from September this year (2002) all newly-qualified nurses and midwives will be given at least a year's employment in NHS Scotland."

However, the Minister warned of complacency. "The challenge now is to build on these developments and come up with innovative solutions to address two further areas which I know staff are concerned about. Their overall workload and the need for more flexible working arrangements to enable them to balance their work and family life. We are determined to step up our efforts on these two issues and will be working closely with the Health Department's new Centre for Change and Innovation on this."

In closing the Minister added, "Only through partnership with staff and their representatives – a partnership approach which lay at the heart of the Facing the Future Action Plan – can we ensure that our aims to address recruitment and retention in NHS Scotland are achieved in both the short and longer term. And that we create a strengthened NHS Scotland workforce which will benefit staff and patients alike."



Case Studies

Mr Chisholm met with a number of nurses representing both Primary and Acute services. The following are some of the case studies from the event.

Additional 250 Students in Training

- ❖ Lisa McBay, Student Nurse, Adult Branch, October 2002, University of Dundee.

Reasons for coming into nursing: "Offers good career options. Challenging, exciting and I enjoy working with people."

- ❖ Mairead McEnvoy, Student Nurse, Adult Branch, October 2002, University of Dundee.

Reasons for coming into nursing: "I have always wanted to be a nurse, as I believe it suits my personality. Nursing is what I see myself doing and being happy while doing it."

- ❖ Gilread Wallace, Student Nurse, Adult Branch, October 2002, University of Dundee.

Reasons for coming into nursing: "I wanted a career with job prospects so I can support my son. Plus you get the job satisfaction of knowing that you've made a difference to someone's life."

Leadership

Alison Struthers: BSc Nursing, RN, RM

Alison Struthers is a Midwife of 15 years' experience, currently working as a Ward Manager of a mixed ante and post-natal ward in Aberdeen Maternity Hospital. As part of the ongoing development, she participated in the RCN Leadership programme based in Grampian. From this came the opportunity to be part of the Facing the Future Implementation Groups at both national and Grampian levels, giving her a broad perspective on issues surrounding the recruitment, retention and development of staff. As a Ward Manager, she supports newly-qualified nurses on a regular basis and has recently benefited from three such appointments. She has played a full part in ensuring that newly-qualified staff have a smooth transition from student to newly-qualified status. This entails discussing

Appendix II: New Nursing Roles-Deciding the Future for Scotland'-10 Principles for Nursing Role Development

Principle 1 Nursing as a unique profession: nursing is a unique profession in which nurses shape and deliver care in partnership with other health and social care professionals

Principle 2 Caring as core: caring is at the core of nursing and must be central to role development

Principle 3 Focused on needs of patient and community: needs of patients, carers and communities should inform the development of professional practice and skills

Principle 4 Ensuring patient safety: nursing practice needs to fit within legal, ethical and regulatory frameworks to ensure patient safety is maintained

Principle 5 Demonstrating leadership: role development should enhance professional leadership, autonomy and clinical credibility

Principle 6 Recognising policy/frameworks: professional development for all nurses should be recognised as a dynamic process, be resourced, and take place within local and national planning frameworks

Principle 7 Integration: there is a need to create a culture to support confident practitioners, by integrating education, practice, research, information technology (IT) and continuing professional development

Principle 8 Evidence-based development: role development should be evidence-based and build the body of nursing knowledge

Principle 9 Evaluation and dissemination: role development should be evaluated and the findings widely disseminated

Principle 10 Enhancing the Profession: role development should enhance the professional recognition, fulfilment, career progression and rewards of nurses.

Appendix III: Nursing & Midwifery Workload & Workforce Planning Project Recommendations (Scottish Executive, 2004)

Recommendation 1: NHS Boards should have in place no later than four months after publication of this report an agreed action plan for taking forward the recommendations. The plan should include a timetable with costing backed by adequate resources and appropriate workforce planning capacity, and must be signed off by the relevant Partnership Forum. The Nurse Director will be the executive sponsor of the plan at Board level, and the action plan will form part of the formal accountability review process. Timeframes for review of systems should be made explicit in the plan.

Recommendation 2: The NHS Board action plan should demonstrate the balance between use of permanent, bank and agency staff. This must include savings targets on use of agency staff and details of how this money (or a proportion) will be re-invested in permanent nursing and midwifery staff.

Recommendation 3: ISD, in partnership with representatives from NHS Boards and other relevant stakeholders, should progress a process to further develop appropriate indicators that allow accurate national comparisons of workload and workforce planning data. Progress towards any new or developed indicators should be reflected through the Performance Assessment Framework, accountability review and staff governance mechanisms.

Recommendation 4: NHS organisations should have in place systems to demonstrate how flexible working practices are contributing to effective use of nursing and midwifery resources, increasing recruitment and retention rates and maximising benefits for patients. Quality indicators could include measures of workforce stability and turnover.

Recommendation 5: The Scottish Executive Health Department should ensure that systematic approaches are applied to nursing and midwifery workload and workforce planning across NHS Scotland.

Recommendation 6: Tools/systems need to be adapted at national level to take account of emerging patient acuity and workload issues, using a systematic process to ensure valid and reliable outcomes.

Recommendation 7: A balance needs to be achieved between resource intensity related to use of nursing and midwifery workload and workforce planning systems and the outputs of these systems.

Recommendation 8: Education and training on the use of recommended nursing and midwifery workload and workforce planning systems should be mandatory prior to implementation of any system, with regular updates made available.

Recommendation 9: Directors of Nursing should lead an education and training needs analysis (E&TNA) of staff contributing to workforce planning locally to identify education and training requirements in relation to establishment setting, budget control and resource allocation. This will help to ensure consistent understanding of concepts and approaches.

Recommendation 10: Continuing support should be provided for appropriate clinical leadership development initiatives at sister/team leader level.

Recommendation 11: A combination of tools should be used, with all services using a nationally agreed 'Telford'-type approach as a minimum.

Recommendation 12: The combination adopted should include a patient dependency²⁴ measure standardized for each of the areas for which questionnaires were developed and sufficiently sensitive to detect changes in patient acuity.

Recommendation 13: NHS Scotland should adopt a standardised approach to determining quality of care. To avoid duplication, outcomes of the work being undertaken nationally by NHS QIS should inform actions on quality tools. Until that project produces its conclusions, a nationally agreed quality tool should be used in conjunction with a workforce planning tool and patient dependency measure

Recommendation 14: To satisfy the expressed wish for standardisation, systems for workforce planning currently being used should be tested to identify which best meet the needs of NHS Scotland.

Recommendation 15: A standardised approach to 'Telford', supported by IT, should be developed and applied consistently across NHS Scotland.

Recommendation 16: A national process for validating National Recommendations should be developed and implemented.

Recommendation 17: Establishments should ensure that nurses and midwives who have overall team leadership responsibility in the direct care area have a minimum 7.5 hours per week of protected time to enable them to focus on leadership, managerial, education and clinical governance-related aspects of their role.

Recommendation 18: The predictable absence allowance should be a minimum of 21%, 27 with a proportion (recommended as 1 of 21%) defined to support systematic management of maternity leave. The calculations on which predictable absence is based and the funding sources to support it should be clearly demonstrated in each nursing and midwifery establishment and NHS Board action plan.

Recommendation 19: Further research on nursing and midwifery workload and workforce planning is required in the specialty areas of paediatrics, psychiatry, and primary care teams.

Recommendation 20: Although any tool used needs to take account of Level 1 patients, additional work in relation to these patients (and equivalents in non-adult acute areas) 28 should be commissioned and undertaken.

Appendix IV: One Year Job Guarantee for Nurses and Midwives

One year job guarantee for nurses and midwives: Guidance fo...

<http://www.scotland.gov.uk/Publications/2010/08/one-year-jo...>

The Scottish Government

Publications

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One year job guarantee for nurses and midwives: Guidance for 2010-2011

Description	Nursery and midwifery employment guidance.
ISBN	(Web Only)
Official Print Publication Date	
Website Publication Date	August 31, 2010

Introduction

This leaflet describes the procedure that has been put in place to implement an arrangement to ensure that every newly qualified nurse and midwife who wishes to work in NHSScotland receives an offer of employment. The intention is that every exiting student nurse or midwife who fulfils the eligibility criteria set out below, receives the offer of a job either through their own means or with assistance. The Scottish Government has developed this guidance in full partnership with the representatives of NHS operating divisions and Boards, universities, and the professional organisations of the RCN, RCM and UNISON.

The guarantee is based on the normal recruitment process, whereby the majority of newly qualified nurses and midwives secure a job through their own efforts informed by their career aspirations and their choice of location. The guarantee is designed to ensure that all newly qualified nurses and midwives have the opportunity to build on the clinical experience gained during their pre-registration programme.

Only, **after having tried to obtain suitable employment**, should a nurse or midwife who has been unable to secure a job in their part of the register or geographical location, and wishes to take advantage of the national scheme, contact NHS Education for Scotland, who will issue them with a list of contacts for operating division vacancies across Scotland. These vacancies will offer at least a one-year contract of employment in NHSScotland.

Of course, neither Scottish Ministers nor NHS Education for Scotland will be employing the newly qualified staff. On taking up one of these jobs, they will be employed by NHS Boards/operating divisions in NHSScotland the same as they would be if they had secured a job independently. The Scottish Ministers will be ensuring that NHSScotland does its best to offer them suitable posts.

The posts will be offered under Agenda for Change Terms and Conditions of Service, subject to the usual checks which will be made regarding suitability for employment for both permanent and fixed-term contracts. Post holders will also be subject to the same professional Codes of Conduct and behaviour that apply to all nurses and midwives who work in NHSScotland. Where the individual chooses to resign from their post or where there is a breach of contract which results in termination of employment in accordance with employment law, the one year guarantee will no longer apply.

Eligibility

All newly qualified nurses and midwives who have qualified from a Scottish university and who are

registering to practice for the first time with a date of registration between 1 September 2010 until 31 August 2011 are eligible to join the national scheme. However, newly qualified nurses and midwives will be expected to be applying for jobs whilst awaiting registration and may be asked to provide written evidence of this. Before they can take up employment as a staff nurse or midwife they must be registered with the Nursing and Midwifery Council (NMC). A nurse or midwife can defer joining the national scheme for up to 3 months after they become registered with the NMC. Only in exceptional circumstances will this period be extended.

What is expected of students/newly qualified nurses or midwives?

During the last 3 months as a student, they are expected to explore all employment opportunities. Thus, before contacting NHS Education for Scotland for a list of contacts they will be expected to have pursued posts of their choice through the normal recruitment process and be able to demonstrate this before choosing to join the one-year job guarantee arrangement. They may be asked to provide written evidence such as copies of application forms.

To join the national scheme

To join the national scheme they should contact NHS Education for Scotland

by post 5th Floor, Thistle House, 91 Haymarket Terrace, EH12 5HD

by email careers@nes.scot.nhs.uk [mailto:careers@nes.scot.nhs.uk]

And quote the one year guarantee arrangement.

They will be required to provide the following information:

- a) Full name**
- b) Date of birth**
- c) Date of registration if available**
- d) PIN number**
- e) Course completed and date**
- f) Institution attended**
- g) Address for correspondence, including email address and fax if available**
- h) List of posts unsuccessfully applied for**

The national scheme will provide contact information for operating divisions vacancies. They will need to follow up these vacancies with the employing operating divisions through the normal application process.

It may not always be possible for the newly qualified nurse or midwife to find a post that exactly meets their preference and they may have to adapt their expectations in light of employment availability.

What is expected of the Scottish Government?

The Scottish Government will enable this guarantee to be met in partnership with the representatives of NHS operating divisions and Boards, NHS Education for Scotland, universities, and the professional organisations of the RCN, RCM and UNISON. Once a written offer of employment, which will last for at least one year has been received, the Scottish Government will consider the guarantee to have been met, unless there are exceptional circumstances where assistance will continue until such time as an offer is made.

What is expected of Higher Education Institutions?

Universities should encourage students to begin seeking employment at the earliest opportunity and should provide support in application form technique and interview skills in the latter stages of their training. Many Higher Education Institutions (HEI) invite local NHS operating divisions and NHS Boards to attend recruitment fairs timed during the students' last 3 months of training, and this is to be welcomed and encouraged. Staff in HEIs should be familiar with the one-year job guarantee arrangement and work in partnership with NHS Education for Scotland in the exchange of information on the newly qualifying nurses

and midwives in their establishment.

What is expected of employers?

NHS Boards are expected, as much as possible, to take appropriate steps to fill suitable vacancies with newly qualified nurses and midwives. They should be familiar with the one year job guarantee arrangement and work in partnership with NHS Education for Scotland in the exchange of information on vacancies.

NHS operating divisions are expected to adopt best practice in the support and mentorship arrangements available in their operating divisions for all newly qualified nurses and midwives. NHS operating divisions should ensure that all fixed-term contracts have a start and end date and contain the same core contractual terms and conditions of employment as permanent staff in line with the legislative framework.

It is anticipated that most students will want full-time employment, however, some may prefer part-time options to suit their particular circumstances.

Employers should take reasonable steps to help the nurse or midwife to find a permanent post during the one year period of employment.

Employment Model for Newly Qualified Nurses & Midwives



Frequently asked questions

1. Do I have to join the one year guarantee?

No, the choice is entirely yours. If you find a post through the normal recruitment process, or if you choose not to work in the NHS following registration, then there is no need to apply to join.

2. When do I join the one year guarantee?

Once you have completed your pre-registration training and are registering with the NMC, you can apply to join the national scheme. You will be expected to demonstrate that you have already taken reasonable steps to secure a post.

3. How will I be asked to demonstrate that I have taken reasonable steps to secure a permanent post?

You will be asked to provide written evidence such as copies of application forms, letters and/or details of

other contacts.

4. Can I delay joining the one year guarantee?

You must join within 3 months of becoming registered with the NMC. Only in exceptional circumstances will this period be extended. Remember, if the period is extended, you will still have been expected to have taken reasonable steps to secure a permanent post through your own efforts.

5. What if I can't find a job that fits my needs?

NHS operating divisions will continue offering you up-to-date lists of vacancies until you are successful in finding a job. Remember, that there may be a need to reconsider particular preferences as time goes on.

6. When does the one year guarantee start?

The year starts as soon as you have accepted and taken up the post being offered to you.

7. Will I have the same terms and conditions as any other employee?

Yes. You will be employed under Agenda for Change Terms and Conditions of Service on the grade that is commensurate with the post and your experience. You will be subject to the same professional Codes of Conduct and behaviour that apply to all nurses and midwives who work in NHSScotland. You will have the same opportunities for Continuous Professional Development including any existing preceptorship/mentorship programmes for newly qualified members of staff. If you choose to resign from your post or where there is a breach of contract which results in termination of employment in accordance with employment law, the one year guarantee will no longer apply.

8. Do I have to complete the one year employment period?

No. Although there is no requirement for you to complete the whole year, for it to be a period of consolidation for you and to get most benefit, it may be helpful to do so. It is not intended that the guarantee is transferable across employers, which means that if you move elsewhere the one year term only applies to the first, and not to the new, job.

9. What happens at the end of the year?

It is anticipated that by the end of the year you will have secured a permanent post of your choice although this cannot be guaranteed.

Support for Newly Qualified Nurses and Midwives

NHS Education for Scotland has a one-year national development programme, Flying Start NHS, for all newly qualified nurses and midwives employed in NHSScotland. The programme aims to help newly qualified staff make the transition from student to full member of the health care team by supporting their learning and building their confidence during the first 12 months of employment.

Using technology, as appropriate, the programme will help nurses and midwives develop skills for lifelong learning and by offering the option of rotational placement experience, will help these new health care professionals plan a rewarding career in NHSScotland.

Appendix V Ethics Approval (Part 1 Scotland)

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow
and Clyde
West of Scotland REC 5
Ground Floor,
Tennant Institute,
Western Infirmary,
38 Church Street,
Glasgow G11 6NT

Telephone: 0141-211-6270
Facsimile: 0141-211-1920

16 July 2009

Miss Noriko Tanishima
Nursing & Health Care
University of Glasgow
59 Oakfield Avenue
Glasgow
G12 8LL

Dear Miss Tanishima

Study Title: A cross cultural study of strategies to maintain the nursing workforce with a particular focus on recently qualified nurses
REC reference number: 09/S1001/43
Protocol number: Appendix 1 Version 1

The Research Ethics Committee reviewed the above application at the meeting held on 15 July 2009. Thank you for attending to discuss the study.

Ethical opinion

The Committee require a few minor amendments to the Study Design and Participant Information Sheet

Study Design

- a. The Committee suggest that recruiting through emails should be sent out to group email addresses rather than individual's email addresses
- b. Question A60 The statistics formula quoted on the ethics application to be deleted as this type of research does not show a representative sample
- c. Question A72 the number host originations to be amended

Participant Information Sheet

- a. Participants to be advised that the questionnaire may take 30 minutes to complete
- b. All references to "newly" should be deleted and replaced with "recently" to read the same as the study title

Consent Form

- va. Question 2 delete "medical care"

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The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Interview Schedules Appendix VIII recently qualified nurses	Version 1	20 May 2009
Letter of invitation to participants Appendix V Questionnaire	Version 1	20 May 2009
Summary CV for supervisor (Student Research)		23 June 2009
Participant Consent Form: Appendix VI	Version 1	20 May 2009
Participant Information Sheet: Appendix III	Version 1	20 May 2009
Participant Information Sheet: Appendix II Interview	Version 1	20 May 2009
Letter of invitation to participant	Appendix IV Interview Version 1	20 May 2009
Questionnaire: Non validated Appendix IX	Version 1	13 May 2009
Interview Schedules/Topic Guides	Appendix VII Nurse Managers Version 1	20 May 2009
Peer Review	Ethics approval letter from Faculty of Medicine University of Glasgow	07 May 2009
Covering Letter		22 June 2009
Protocol	Appendix 1 Version 1	15 June 2009

WoSRES
West of Scotland Research Ethics Service



West of Scotland Committee 1
Western Infirmary
Ground Floor
Tennant Institute
38 Church Street
Glasgow
G11 6NT

Telephone : 0141 211 6270
Fax : 0141 211 1847

Date : 30th July 2009

Email: sharon.jenner@ggc.scot.nhs.uk

Miss Noriko Tanishima
Nursing and Health Care
University of Glasgow
59 Oakfield Avenue
Glasgow
G12 8LL

Dear Miss Tanishima

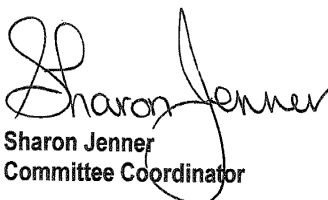
Project : 09/S1001/43 A cross cultural study of strategies to maintain the nursing workforce with a particular focus on recently qualified nurses

I should like to acknowledge the content of letter dated 23rd July 2009 from you enclosing the following approved amended documents

1. IRAS ethics application form
2. Participants Information Sheet Interview version 2 22/07/2009
3. Participants Information Sheet Questionnaire version 2 22/07/2009
4. Consent Form version 2 22/07/2009
5. Questionnaire version 2 22/07/2009

These will be held on file

Yours sincerely,



Sharon Jenner
Committee Coordinator

c.c Prof N Smith
R & D Department

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Appendix VI: Management Approval (Part 1 Scotland)



Coordinator/administrator: Darren Gibson/Elaine O'Donnell
 Telephone Number: 0141 211 6208
 Fax Number: 0141 211 2811
 E-Mail: Darren.Gibson@ggc.scot.nhs.uk

R&D Management Office
 Western Infirmary
 Tennent Institute
 1st Floor, 38 Church Street
 Glasgow, G11 6NT

16 September 2009

Miss Noriko Tanishima
 Nursing and Health Care
 University of Glasgow
 59 Oakfield Avenue
 Glasgow G12 8LL

R&D Management Approval

Dear Miss Tanishima,

Project Title: A cross cultural study of strategies to maintain the nursing workforce with a particular focus on recently qualified nurses

Chief Investigator: Miss Noriko Tanishima

R&D Reference: GN09NR300 NRS09/NR11

Protocol: Version 1 15/06/09

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Management Approval** for the above study.

As a condition of this approval the following information is required during the lifespan of the project:

1. SAES/SUSARS – If the study is a **Clinical Trial** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004 (CTIMP only)
2. Recruitment Numbers on a quarterly basis (not required for commercial trials)
3. Any change of Staff working on the project named on the ethics form
4. Change of CI
5. Amendments – Protocol/CRF etc
6. Notification of when the Trial / study has ended
7. Final Report
8. Copies of Publications & Abstracts

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Yours sincerely

Dr Darren Gibson
 Research Co-ordinator

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Appendix VII: Ethics Approval for Change in November (Part 1 Scotland)

WoSRES
West of Scotland Research Ethics Service



West of Scotland REC 5

Ground Floor,
Tennent Institute,
Western Infirmary,
38 Church Street,
Glasgow G11 6NT

Tel: 0141-211-6270
Fax: 0141-211-1847

19 November 2009

Miss Noriko Tanishima
Nursing & Health Care
59 Oakfield Avenue
Glasgow
G12 8LL

Dear Miss Tanishima

Study title: A cross cultural study of strategies to maintain the nursing workforce with a particular focus on recently qualified nurses
REC reference: 09/S1001/43
Amendment number: Amendment 1
Amendment date: 03 November 2009

The above amendment was reviewed at the meeting of the Committee held on 18 November 2009.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Poster	Version 1	30 October 2009
Notice of Substantial Amendment (non-CTIMPs)	Amendment 1	03 November 2009
Covering Letter		03 November 2009

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

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Appendix VIII: Management Approval from one hospital (Part 1 Scotland)

Golden Jubilee National Hospital

National Waiting Times Centre Board

Chairperson Lindsay Burley
Chief Executive Jill Young

Beardmore Street
Clydebank G81 4HX
Scotland
Telephone 0141 951 5000



Alistair Flowerdew

Medical Director

Tel: 0141 951 5665

Fax: 0141 951 5007

Secretary: 0141 951 5957

E-mail: alistair.flowerdew@gjnh.scot.nhs.uk

14 October 2009

Miss Noriko Tanishima
Nursing and Health Care
University of Glasgow
59 Oakfield Avenue
Glasgow
G12 8LL

Dear Miss Tanishima,

Management Approval for a non-commercial research project

I am pleased to tell you that you now have Management Approval for the research project entitled: **A Cross cultural study of strategies to maintain the nursing workforce with a particular focus on recently qualified nurses**. I acknowledge that:

- The project is sponsored by the **University of Glasgow**.
- Research Ethics approval for the project has been obtained from the **West of Scotland Research Ethics Committee 1** (reference number: 09/S1001/43).
- The Site Specific Form for this project has been reviewed and there is no objection to it proceeding at this site.

The following conditions apply:

- This study will be subject to ongoing monitoring for Research Governance purposes and may be audited to ensure compliance with the Research Governance Framework for Health and Community Care in Scotland (2006, 2nd Edition), however prior written notice of audit will be given.
- All amendments (minor or substantial) to the protocol or to the REC application should be forwarded to the NWTCB Research Office with a copy of the amendment application and approval letter.
- You cannot access this site for research purposes until you have received an Honorary Research Contract which will be issued by the NWTCB Human Resources Department.

Please report the information detailed above, or any other changes in resources used, or staff involved in the project, to the National Waiting Times Centre Board Research Manager, Dr Catherine Sinclair (0141 951 5440, catherine.sinclair@gjnh.scot.nhs.uk).

Further information about research at the National Waiting Times Centre Board can be found at the following website: www.nhsgoldenjubilee.co.uk/home/research.php.

Yours sincerely,

A handwritten signature in black ink, appearing to be 'Alistair Flowerdew', written in a cursive style.

Mr Alistair Flowerdew
Medical Director

cc: Dr Catherine Sinclair, Research Manager, National Waiting Times Centre Board, Golden Jubilee National Hospital, Beardmore Street, Clydebank, G81 4HX

Appendix IX: Letter of Invitation for Interviews (Part 1 Scotland)



Dear name

Letter of Invitation: Interview

A cross cultural study of strategies to maintain the nursing workforce with a particular focus on recently qualified registered nurses.

I am writing to invite you to take part in a study. The aim of this study is to identify similarities and differences between Scotland and Japan regarding the impact of government policies related to recently qualified nurses in the critical care/high dependency nursing workforce. We are hoping that results and findings of this study will suggest new approaches to develop policies regarding the retention and recruitment of a new generation of nurses. This study is a part of my PhD degree and is being supervised by Professor Lorraine N Smith at University of Glasgow.

I have enclosed the Participant Information Sheet, Consent form and Interview Guide that provide you with an understanding of the study and what your participation will involve. After careful reading and consideration, if you agree to take part in this study please send an email to the following address (0406253@clinmed.gla.ac.uk) to inform me that you would like to participate with your contact details indicating how you would like me to contact you.

If you have any questions about this study or the questionnaire, do not hesitate to contact me. We hope you find this study interesting and thank you very much in advance for your support.

Yours sincerely

Noriko Tanishima
PhD Student
Nursing & Health Care
Faculty of Medicine
University of Glasgow
59 Oakfield Avenue
Glasgow G12 8LL

Tel: [REDACTED]
Email: [REDACTED]

[REDACTED]
Nursing & Health Care
Faculty of Medicine
University of Glasgow
59 Oakfield Avenue
Glasgow G12 8LL

Tel: [REDACTED]
Email: [REDACTED]

Appendix X: Participant Information Sheet for Interviews (Part 1 Scotland)



Research Participant Information Sheet: Interview

A cross cultural study of strategies to maintain the nursing workforce with a particular focus recently qualified registered nurses

You are being invited to take part in a research study. It is important for you to understand why the research is being done and what it will involve before you make decision. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of this study?

The aim of this study is to identify similarities and differences between Scotland and Japan regarding the impact of government policies related to recently qualified nurses in the critical care/high dependency nursing workforce. This research is a part of PhD degree, and is being supervised by Professor Lorraine N Smith, University of Glasgow

Scientific justification of this study

Nurses are generally acknowledged to be a critical component of the health care system. Numerous studies demonstrate their impact on patient outcomes and nurses play a key role in providing direct patient care. However, nursing workforce planning is challenging for nurses, managers and organisations. Maintaining the nursing workforce, not only in terms of numbers, but also in terms of quality of the nursing workforce has been an internationally prioritised issue. Government policies have been published and various approaches undertaken. However, there is little evidence of the impact of these strategies and there is no comparison study between Japan and Scotland. Thus, this study will identify similarities and differences between Scotland and Japan regarding the impact of government policies related to recently qualified nurses in the critical care/high dependency nursing workforce. We are hoping that results and findings of this study will suggest new approaches to develop policies regarding the retention and recruitment of a new generation of nurses.

The reason why you have been chosen as participant

You have been chosen for one of the following reasons:

- You are involved in the programme 'Flying Start' and/or 'Early Career Fellowships': and/or
- You are familiar with the implementation of the government policy and issues related to nursing workforce at local level; and/or
- You are directly involved in government initiatives related to nursing workforce planning.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you.

What does taking part involve?

If you decide to take part you will be asked to participate in an interview with the researcher that will take approximately 30 minutes. The interview will be held at in a private space in your working place at your convenience. Questions to be asked at the interview are enclosed with this

letter. The interview will be recorded on digital recorder with your permission for the purpose of data analysis.

How will the information I provided be used?

All information from the interview will be anonymised and will be treated confidentially. The recorded interview will be transferred from the digital recorder to a password protected, secured computer. The data will be accessible only to the researcher. The recorded interview will be deleted on study completion.

What are the possible disadvantages and risks of taking part?

There are no disadvantages or risks to taking part in this study. The interview will take 30 minutes, and we appreciate your time.

What are the possible benefits of taking part?

There is no direct benefit to you to take part of this study. However, this will allow us to understand your situation and also to inform others that follow.

What should I do if I decide to take part?

I would very much appreciate it if you could email me to the following address (0406253@clinmed.gla.ac.uk) with your contact details how you would like me to contact you (e.g. email, letter, telephone) by [REDACTED]. I will contact you via email or phone or letter, which you have provided, to set up the interview date. The consent form will be collected at the beginning of the interview.

If you have any questions about this study, do not hesitate to contact me.
0406253@clinmed.gla.ac.uk We hope you find this study interesting and thank you very much in advance for your support.

This is a part of my PhD degree. The results of this study will be available from the University Library, journal articles, and conference presentation. You will receive an executive summary of this study.

Yours sincerely,

Noriko Tanishima
PhD Student
Nursing & Health Care
Faculty of Medicine
University of Glasgow
59 Oakfield Avenue
Glasgow G12 8LL

Tel: [REDACTED]
Email: [REDACTED]

Professor Lorraine N Smith

Nursing & Health Care
Faculty of Medicine
University of Glasgow
59 Oakfield Avenue
Glasgow G12 8LL

Tel: [REDACTED]
Email: [REDACTED]

Appendix XI: Consent Form (Part 1 Scotland)



CONSENT FORM

Title of Project: A cross cultural study of strategies to maintain the nursing workforce with a particular focus on recently qualified registered nurses

Name of Researcher: Noriko Tanishima

Please initial box

1. I confirm that I have read and understand the information sheet dated 22/07/2009 version 2 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.
3. If selected to take part in the semi-structured interview, I give permission for the interview to be audio digital recorded with the possible use of verbatim quotes. This will be confidential and all information anonymised.
4. I agree to take part in the above study.

☐
☐
☐
☐

Name of participant

Date

Signature

.....

.....

.....

Name of person taking consent

Date

Signature

.....

.....

.....

Name of researcher

Date

Signature

.....

.....

.....

When completed, 1 for participant; 1 for researcher site file

Appendix XII: Interview Guide for NHS Nurse Managers (Part 1 Scotland)



University of Glasgow · Nursing & Health Care

Interview Guide for Nurse Managers

A cross cultural study of strategies to maintain the nursing workforce with a particular focus on newly qualified registered nurses.

Workforce planning for nurses has been a key issue for the last 5-7 years. Policies like 'Facing the Future', 'Delivering for Health', 'Delivering Care Enabling Health', and 'Better Health Better Care' have had some specific objectives to recruit and retain the nursing workforce. I would like to ask you several questions about your opinions and perceptions about these government policies in terms of nursing workforce planning generally.

Q1: What were your expectations of policies like 'Facing the Future', 'Delivering for Health', 'Delivering Care Enabling Health', and 'Better Health Better Care' in terms of nursing workforce planning?

Q2: To what extent do you think the outcomes of 'Facing the Future', 'Delivering for Health', 'Delivering Care Enabling Health', and 'Better Health Better Care' have been met?

Q3: In your opinion, how has the situation of the nursing workforce changed over the past 5 years as result of these government initiatives?

Q4: Are there any other concerns or issues emerging from these initiatives?

Q5: What do you think the key factors have been in achieving the goals of these policies?

Q6: Are there any particular projects or programmes that seem to be making a good progress?

Now, I would like to ask you some questions especially related to recently qualified nurses of 24 months or less. There are several projects and programmes related to recently qualified nurses, such as 'Flying Start' and 'Early Clinical Career fellowships'.

Q7: What were your expectations of 'Flying Start' and/or 'Early Clinical Career Fellowships' initially?

Q8: Why do you think some of the government initiatives like 'Flying Start' and 'Early Career Fellowships' so attractive to recently qualified nurses?

Q9: To what extent do you think the outcomes of 'Flying Start' and/or 'Early Clinical Career Fellowships' have been met?

Q10: In your opinion, how has the situation of recently qualified nurses changed over the past 5 years as result of government initiatives including the programmes mentioned above?

Q11: Are there any other concerns or issues emerging from these programmes?

Q12: What do you think the key factors are in achieving the goals of these programmes?

Q13: Are there any unique programmes in your ward which target at newly qualified nurses?

Q14: Is there anything else you think I should know about this topic?

Appendix XIII: Interview Guide for Recently Qualified Nurses (Part 1 Scotland)



University of Glasgow Nursing & Health Care

Interview Guide for Recently Qualified Nurses

A cross cultural study of strategies to maintain the nursing workforce with a particular focus on recently qualified registered nurses.

It is challenging at the early stage of your career as a nurse to familiarise yourself with new environment and develop your professional identity. I would like to ask you some questions about your experience as a nurse at early stage of your career as nurse.

Q1: How have you found the last 24 months in terms of familiarising yourself into clinical practice as a nurse?

Q2: What do you think are the key factors in your transition from a nursing student to a nurse?

Q3: Please describe briefly the organizational support you have been given since you started working to help your transition from a nursing student to a nurse.

Q4: What were your expectations of organizational support to help your role transition?

Q5: To what extent are you satisfied with the organizational support you have been given?

Now, I would like to ask you questions about 'Flying Start' and/or 'Early Clinical Career Fellowships'.

Q6: could you tell me the reason why you are involved in 'Flying Start' and/or 'Early Clinical Career Fellowships'?

Q7: To what extent are you satisfied with 'Flying Start' in terms of familiarising yourself into clinical practice?

Q8: To what extent are you satisfied with 'Early Clinical Career Fellowships' in terms of helping your career development?

Q9: Please describe a good experience of being involved in 'Flying Start' and/or 'Early Clinical Career Fellowships'

Q10: Please describe a poor experience of being involved in 'Flying Start' and/or 'Early Clinical Career Fellowships'

Q11: Did you have any concerns about being involved in 'Flying Start' and/or 'Early Clinical Career Fellowships'?

Q12: Would you recommend these programmes to other nurses? Why?

Q13: Is there anything you would want changed in these programmes? Why?

Q14: What kind of factors do you think have made your experience of moving from a nursing student to a nurse, good?

Q15: Is there anything else you think I should know about this topic?

Appendix XIV: Letter of Invitation for Questionnaires (Part 1 Scotland)



Date

Dear name

Letter of Invitation: Questionnaire

A cross cultural study of strategies to maintain the nursing workforce with a particular focus on recently qualified registered nurses.

I am writing to invite you to take part in a study. The aim of this study is to identify similarities and differences between Scotland and Japan regarding the impact of government policies related to recently qualified nurses in the critical care/high dependency nursing workforce. We are hoping that results and findings of this study will suggest new approaches to develop policies regarding the retention and recruitment of a new generation of nurses.

This study is a part of my PhD degree and is being supervised by Professor Lorraine N Smith at University of Glasgow

I have enclosed the Participant Information Sheet, which provides you with an understanding of the study and what your participation will involve, together with questionnaire and the SAE. After careful reading and consideration, if you agree to take part in this study please complete the questionnaire and send it back to the address provided on the SAE.

If you have any questions about this study or the questionnaire, do not hesitate to contact me. We hope you find this study interesting and thank you very much in advance for your support.

Yours sincerely

Noriko Tanishima
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Tel: [REDACTED]
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Professor Lorraine N Smith

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Email: [REDACTED]

Appendix XV: Participant Information Sheet for Questionnaire (Part 1 Scotland)



Research Participant Information Sheet: Questionnaire

A cross cultural study of strategies to maintain the nursing workforce with a particular focus on recently qualified registered nurses

You are being invited to take part in a research study. It is important for you to understand why the research is being done and what it will involve before you make decision. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of study?

The aim of this study is to identify similarities and differences between Scotland and Japan regarding the impact of government policies related to recently qualified nurses in the critical care/high dependency nursing workforce. This research is a part of PhD degree, and is being supervised by Professor Lorraine N Smith, University of Glasgow.

Scientific justification of this study

Nurses are generally acknowledged to be a critical component of the health care system. Numerous studies demonstrate their impact on patient outcomes and nurses play a key role in providing direct patient care. However, nursing workforce planning is challenging for nurses, managers and organisations. Maintaining the nursing workforce, not only in terms of numbers, but also in terms of quality of the nursing workforce has been an internationally prioritised issue. Government policies have been published and various approaches undertaken. However, there is little evidence of the impact of these strategies and there is no comparison study between Japan and Scotland. Thus, this study will identify similarities and differences between Scotland and Japan regarding the impact of government policies related to recently qualified nurses in the critical care/high dependency nursing workforce. We are hoping that results and findings of this study will suggest new approaches to develop policies regarding the retention and recruitment of a new generation of nurses.

The reason why you have been chosen as participant

You have been chosen as a hospital based nurse to help us to understand the impact of government policies related to recently qualified nurses in the critical care /high dependency nursing workforce.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you.

What does taking part involve?

If you decide to take part you will be asked to complete the questionnaire that will take you approximately 30 minutes. Completion of the questionnaire will be taken as consent to participate.

How will the information I provide be used?

All information from the questionnaire will be anonymised and will be treated with sensitivity. The data will be grouped and held in a secure computer and will be accessible only to the researcher. Original questionnaire and data in the computer will be destroyed on the completion of the study.

What are the possible disadvantages and risks of taking part?

There are no disadvantages and risks. However, you may feel uncomfortable to answer several questions about your feeling towards your employee and working environment. The questionnaire will take 30 minutes to complete, and we appreciate your time.

What are the possible benefits of taking part?

There is no direct benefit to you to take part of this study. However, this will allow us to understand your situation and also to inform others that follow.

What should I do if I decided to take part?

I would very much appreciate it if you could return this questionnaire after you complete it by [REDACTED]. If you have any questions about this study or the questionnaire, do not hesitate to contact me. (0406253@clinmed.gla.ac.uk) We hope you find this study interesting and thank you very much in advance for your support.

This is a part of my PhD degree. The results of this study will be available from the University Library and the executive summary will be sent to you via email if you wish. If you would like to receive the executive summary via email, please provide us your email address on a separate paper attached with the questionnaire.

Yours sincerely,

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Professor Lorraine N Smith

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Appendix XVI: Questionnaires (Part 1 Scotland)**A cross cultural study of strategies to maintain the nursing workforce
with a particular focus on recently qualified registered nurses****Questionnaire**

This questionnaire should take about 30 minutes to complete.
All responses will be anonymised and no individual or institution will be identified.
We hope you find something interesting in this questionnaire.

Demography

Please tick the appropriate box for each question.

1. Are you male or female?

- ☐ Female
☐ Male

2. How long have you been working in your current position?

- ☐ 12 months or less
☐ 13months -5 years
☐ 6-10 years
☐ 11-15 years
☐ 16-20 years
☐ More than 20 years

3. What is your highest educational award?

- ☐ Pre-registration Diploma
☐ Post-registration Diploma
☐ Degree
☐ Master
☐ PhD
☐ Other - please state _____

4. How long have you been registered?

- ☐ 24 months or LESS
☐ 2-5 years
☐ 6-10 years
☐ 11-15 years
☐ 16-20 years
☐ More than 21 years

Please answer sections 2 &3 from page5

→ **Please answer sections 1&3
(from page 3)**

Section 1: Nurses registered for MORE than 24 months

In relation to your job

For each statement please indicate how things have changed for you over the last 12 months by ticking the box which best reflects your opinion.

During the last 12 months	Decreased		Stayed about the same	Increased	
	A lot	A little		A little	A lot
5. The sense of personal achievement I get from work has					
6. The levels of stress I feel, have					
7. My feelings of being a valued employee have					
8. The morale of my colleagues has					
9. My workload has					
10. The quality of care I am able to give has					
11. The resources I have to provide care have					
12. My job satisfaction has					
13. My feeling of job security has					
14. Staffing levels have					
15. My satisfaction with my overall working conditions has					
16. My satisfaction with my pay has					
17. The amount of time I have for direct patient care has					
18. The quality of communication with managers has					
19. My responsibilities have					
20. The amount of time I have to talk to patients has					

*Questions 5-20 were originally developed by Nolan et al 1998 and have been adapted with the author's permission.

Section 1: Nurses registered for MORE than 24 months

21. How much are you aware of Scottish Government health policies related to your area of clinical practice? Please tick the most appropriate box.

- ☐ A great deal
- ☐ Very much
- ☐ To some degree
- ☐ A little
- ☐ Not at all

22. How much are you aware of Scottish Government policies related to nursing workforce planning? Please tick the most appropriate box.

- ☐ A great deal
- ☐ Very much
- ☐ To some degree
- ☐ A little
- ☐ Not at all

23. How much do you think Scottish Government health policies have had an impact on your area of clinical practice? Please tick the most appropriate box.

- ☐ A great deal
- ☐ Very much
- ☐ To some degree
- ☐ A little
- ☐ Not at all

24. Are you involved with programmes targeted at supporting recently qualified nurses, registered for 24 months or less? Please tick all appropriate boxes.

- ☐ Early Career Fellowship as a fellow
- ☐ Flying Start as a Mentor
- ☐ Heard of them, but not involved
- ☐ Never heard of them
- ☐ Involved but in a different role. Please specify your role in the box below.

Please Go to Section 3, page 9

Section 2: Recently Qualified Nurses registered for 24 months or LESS

In relation to your experience as a recently qualified nurse
--

25. How often have you found yourself having difficulties in familiarising yourself in clinical practice as a nurse?

- ☐ Always
☐ Occasionally
☐ Hardly ever
☐ Never

To what extent have the following factors made it difficult for you to familiarise yourself into clinical practice? Please tick the most appropriate box for each statement.

	A great deal	Very much	To some degree	A little	Not at all
26. My lack of knowledge about essential nursing care (e.g. procedures like wound dressings,; monitoring physiological symptoms)					
27. A lack of professional skills and knowledge in my clinical work environment					
28. A lack of communication skills with patients, peers, and other colleagues					
29. A lack of opportunity for on the job training					
30. Lack of support from my peers					
31. A lack of support from my family and friends					
32. A lack of a role model to help develop my career expectations and professional identity					
33. Either lack of feedback or negative feedback or lack of feedback from peers					
34. Either lack of feedback or negative feedback from patients and their families					
35. The gap between my expectation of nursing at graduation and what I have found in clinical practice					
36. Negative feelings towards my job and working environment (e.g. overwork, shift pattern, fear of making mistakes)					
37. Doubts about my ability to be a good nurse					

Factors 26-37 are based on 'A survey of rapid turnover among newly qualified nurses', Japanese Nursing Association 2004.

Section 2: Recently Qualified Nurses registered for 24 months or LESS

38. If there are any other factors that have made it difficult for you to familiarise yourself into clinical practice, could you please specify in the box below.

39. What kind of factors do you think would have made it easy for you to familiarise yourself into clinical practice? Please specify in the box below.

40. Other than an ‘Early Clinical Career Fellowships’ or ‘Flying Start’, please describe briefly in the box below about the organisational support you have been given to familiarise you into clinical practice since you started working.

(e.g. mentorship, training course, workshop,)

41. To what extent are you satisfied with your organisation’s support to familiarise you into clinical practice since you started working? Please tick the most appropriate box.

- ☐ Very satisfied
- ☐ Moderately satisfied
- ☐ Neither satisfied or dissatisfied
- ☐ Moderately dissatisfied
- ☐ Very dissatisfied

42. To what extent do you think organisational support is helpful for you to familiarise you into clinical practice? Please tick the most appropriate box.

- ☐ A great deal
- ☐ Very much
- ☐ To some degree
- ☐ A little
- ☐ Not at all

Section 2: Recently Qualified Nurses registered for 24 months or LESS

43. Are you involved or used to be involved in any of the following programmes? Please tick all appropriate boxes.

- ☐ Early Clinical Career Fellowships
- ☐ Flying Start
- ☐ Heard of them, but not involved
- ☐ Never heard of them

44. If your answer was 'heard of them but not involved' could you please tick all the reasons why you are not involved.

- ☐ I was not interested in it.
- ☐ I was not given the opportunity to be involved.
- ☐ I was not able to gain the organisation's support.
- ☐ I am considering being involved but have not yet decided.
- ☐ Other (could you please specify the reason in the box below)

45. Are you currently involved in 'Early Clinical Career Fellowships' as a fellow? Please tick the appropriate box.

- ☐ Yes → Go to Question 46
- ☐ No → Go to Question 47

46. To what extent do you believe that 'Early Clinical Career Fellowships' are helpful in terms of developing clinical skills and your career? Please tick the most appropriate box.

- ☐ A great deal
- ☐ Very much
- ☐ To some degree
- ☐ A little
- ☐ Not at all

47. Are you currently involved or were you involved in 'Flying Start'? Please tick the appropriate box.

- ☐ Yes → Go to Question 48
- ☐ No → Go to Question 49

Section 2: Recently Qualified Nurses registered for 24 months or LESS

48. To what extent is 'Flying Start' helpful in terms of familiarising yourself into clinical practice? Please tick the most appropriate box.

- ☐ A great deal
- ☐ Very much
- ☐ To some degree
- ☐ A little
- ☐ Not at all

49. Overall, how would you describe your experience of being a recently qualified nurse? Please tick the most appropriate box.

- ☐ Very good
- ☐ Good
- ☐ Neither good nor bad
- ☐ Bad
- ☐ Very bad

Please Go to Section 3 next page

Section 3: All Registered Nurses

In relation to your working environment

To what extent do you agree with the following statements regarding your working environment? Please tick the most appropriate box for each statement.

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
50. Our hospital believes that it is important for me to spend time with my patients.				
51. Doctors and nurses have good working relationships.				
52. Our hospital has managerial staff that are supportive of nurses.				
53. Our hospital has active inservice/ continuing professional education programmes for nurses				
54. Our hospital has career development opportunities				
55. Our hospital has opportunities for staff nurses to participate in policy decisions				
56. Managers use mistakes as learning opportunities, not for criticising				
57. We have enough time and opportunity to discuss patient care problems with other nurses.				
58. Our ward has enough registered nurses on staff to provide quality patient care				
59. We have a ward manager/senior charge nurse/ ward sister who is a good manager and leader				
60. Our Division's Nursing Lead is highly visible and accessible to staff				
61. Our hospital has enough staff to get the work done				
62. We receive praise and recognition for a job well done				
63. High standards of nursing care are expected by the organisation				
64. The Nursing Lead in my Division is equal in power and authority to other Divisional leads				

Section 3: All Registered Nurses

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
65. There is much teamwork between nurses and doctors				
66. We have opportunities for advancement				
67. We have a clear philosophy of nursing that pervades the patient care environment				
68. We are working with nurses who are clinically competent				
69. We have a ward manager/senior charge nurse/ ward sister who backs up the nursing staff in decision making, even if the conflict is with a physician				
70. Our organisation listens and responds to employee concerns				
71. We have an active quality-assurance programme				
72. Staff nurses are involved in the internal governance of the hospital (e.g. practice and policy committees)				
73. We have collaboration between nurses and physicians				
74. We have a mentorship programme for recently qualified registered nurses.				
75. Nursing care is based on a nursing rather than a medical model				
76. Staff nurses have the opportunity to serve on hospital and nursing committees.				
77. Ward managers/senior charge nurses/ ward sisters consult with staff on daily problems and procedures.				
78. Our nursing care plans for all patients are up-to-dated and shared.				
79. Patient allocation fosters continuity of care (i.e., the same nurse cares for the patient from one day to the next.)				

*Questions 50-79 are derived from a tool developed by Aiken 2000, modified by Lake 2002 and adapted for the purpose of this study.

Section 3: All Registered Nurses**In relation to your career perspective**

80. How often have you thought about leaving your current position within the last 12 months?

- ☐ Never
- ☐ Occasionally in the last 12 months
- ☐ Sometimes every month
- ☐ Sometimes every week
- ☐ Every day

81. How often have you thought about giving up nursing within the last 12 months?

- ☐ Never
- ☐ Occasionally in the last 12 months
- ☐ Sometimes every month
- ☐ Sometimes every week
- ☐ Every day

Thank you very much for your participation.

Optional

Please write down your email address in the box if you would like to receive an executive summary from us via email.

Your email address will be held on a secure computer and will be used for this purpose only and the information destroyed once the executive summary has been distributed. The results of this study will also be available at the University of Glasgow's Library.

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Appendix XVII; Study Protocol (Part 1 Scotland)



Protocol

Study Title: A cross cultural study of strategies to maintain the nursing workforce with a particular focus on recently qualified registered nurses

Research aim: The aim of this study is to identify similarities and differences between Scotland and Japan regarding the impact of government policies related to recently qualified nurses in the critical care/high dependency nursing workforce.

Research questions

1. What government-driven policy exists to maintain the recently qualified nursing workforce in Scotland and Japan?
2. To what extent are registered nurses in clinical practice aware of these policies?
3. What are the responses of clinical practice to these workforce policies?
4. Do nurse managers and RQNs have issues and/or concerns related to these workforce policies?
5. Can an understanding of questions 1-4 suggest how policies related to RQNs could be better developed and implemented

Background of this study

Nurses are generally acknowledged to be a critical component of the health care system. Numerous studies demonstrate their impact on patient outcomes and nurses play a key role in providing direct patient care. However, nursing workforce planning is challenging for nurses, managers and organisations. Maintaining the nursing workforce, not only in terms of numbers, but also in terms of quality of the nursing workforce has been an internationally prioritised issue. Government policies have been published and various approaches undertaken. However, there is little evidence of the impact of these strategies and there is no comparison study between Japan and Scotland. There are a number of reasons why the comparison between Japanese and Scottish nurses would be of interest. First both countries have a national health service. Both countries face similar issues in terms of an ageing workforce, ageing population, and increased budget for national health insurance. The internal organisation of hospitals in Scotland and Japan is sufficiently close to allow comparisons to be made between countries. Both countries educate their nursing workforce to degree level. For these reasons, a cross-cultural study would generate some useful insights into the implementation of government strategies and impact on nursing workforce. This study will identify similarities and differences between Scotland and Japan regarding the impact of government policies related to recently qualified nurses in the critical care/high dependency nursing workforce. Results and findings of this study should suggest new approaches to develop policies regarding the retention and recruitment of a new generation of nurses.

Study Design

Multi-methods will be applied to this study. This study is composed of two parts. Part 1 is in Scotland and Part 2 is in Japan. Part 1 will be divided into two phases. Phase 1 are interviews with NHS managers Phase 2 are questionnaires with NHS staff. The data will be collected by face to face (audio-recorded) interviews using a semi-structured interview schedule. The semi-structured interview will be undertaken to gain the perception, opinions and ideas of government policy and implementation among nurse managers regarding workforce planning and recently qualified registered nurses. The questionnaire will be conducted to examine the impact of implementation on the nursing workforce at local level with hospital based registered nurses.

Ethics Approval

Part 1: Scotland

Ethical approval has been gained in Scotland. Ethics Approval for interviews and a questionnaire with NHS staff is subject to Ethics (IRAS) approval.

Part 2: Japan

This is subject to ethics review in Japan.

Pilot and Main Study Sites

Study sites will be the following hospitals:

- Stobhill Hospital
- Royal Infirmary
- Gartnavel General
- Southern General
- Western Infirmary
- Golden Jubilee Hospital

Samples and Sample Size

Part 1: Scotland

Interviews

The study sample for the semi-structured interviews will be identified by purposive sampling to meet the inclusion criteria. Interviews will be held with NHS staff..

The samples will be the following:

- 5 nurse managers from the NHS who are involved in government initiatives related to nursing workforce planning
- 10 ward managers/ charge nurses/ ward sisters in ITUs/HDUs/CCUs/ICUs at the study sites
- 15 recently qualified nurses registered for 24 months or less, who have been involved in 'Flying Start' or Early Clinical Career Fellowships' and are working in ITU/HDU/CCU/ICU.

Questionnaire

The sample for the questionnaire will be identified by purposive and convenience sampling to meet the inclusion criteria as follows:

- Registered nurses working with adult patients in ITUs/HDUs/ICUs/CCUs in one of the study sites

The exclusion criteria will be the following.

- Bank nurses

The questionnaire will be distributed to 200 registered nurses.

Recruitment

Part 1: Scotland

Having gained approval to access nurses in the study sites from the Director of Nursing, Greater Glasgow and Clyde, nurse managers will be accessed and recruited directly via letter by the researcher. Nurses will be identified by ward managers and accessed through ward managers. With permission, the researcher will attend the ward staff meeting to publicise the study and recruit nurses.

Pilot Study

A pilot study will be conducted to test questionnaire content and the interview guide at ITUs/ICUs/HDUs/CCUs in GGCNHS hospitals and these sites will be excluded from the main study.

Data collection

The questionnaire package including Letter of Invitation, Participant Information Sheet, and Questionnaire with a SAE will be distributed by ward managers.

Face to face digital audio recorded interviews will be undertaken with nurse managers and recently qualified nurses. The interview will last 30 minutes. The interview will be digitally audio recorded with participant's permission.

Confidentiality of Data

The interview will be recorded with permission. The digital audio recorded interview will be held in a secure computer at the University of Glasgow and will be only accessible to the chief investigator.

The questionnaire will ask the participants if we can have their email address and hold this information on a secure computer to facilitate the distribution of the study outcomes via executive summary. These email addresses will be used only for this purpose and the information destroyed thereafter. The original returned questionnaire will be stored in a locked cabinet at the University of Glasgow in the academic supervisor's office. The data from returned questionnaires will be coded and held in a secure computer at the University of Glasgow and will be only accessible to the researcher.

Data presentation will be anonymised and confidentiality will be guaranteed. The data will be deleted on the completion of study.

Data Analysis

Data will be stored into the computer with secured access by only the researcher and all data including recorded interview will be destroyed after the study. Interview data analysis will be performed with SPSS and content analysis. After the data analysis, Japanese data will be translated into English. Questionnaire data will be subjected to simple descriptive statistics.

Dissemination

Executive summary to all participants via email and by peer-reviewed publications.

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Appendix XVIII: Initial Contact Letter/Email Ward Managers (Part 1 Scotland)

 **University of Glasgow** · Nursing & Health Care
3rd November 2009

[Redacted]

Dear [Redacted]

I have been given your name by [Redacted]. I hope you do not mind me contacting you.

I am writing this letter to ask if you would be happy to support my study in terms of recruiting nurses for my study. I have been given permission to contact you by the Director of Nursing [Redacted] and I have been granted ethics and R&D approval for this study. I enclosed the study protocol for your information.

I am a PhD student at University of Glasgow, supervised by [Redacted]. My study is about the impact of government policies related to recently qualified nurses in the critical care/high dependency nursing workforce in Japan and Scotland. I plan to interview nurses managers and recently qualified nurses (registered for 24 months or less) who are involved in 'Flying Start' and/or 'Early Clinical Career Fellowships'. I also would like to distribute a questionnaire to registered nurses working at ICU/CCU/HDU to ask them their perception of their working environment and workplace change.

I would like to ask your support in the following ways.

1. I would like to ask your permission to conduct my study on your ward.
2. I would like you to help me to recruit recently qualified nurses who meet the inclusion criteria of this study (Registered for 24 months or less and are involved in 'Flying Start' and/or 'Early Clinical Career Fellowships') by distributing the recruitment package to them on your ward.
3. If there are recently qualified nurses on your ward, you could help me in distributing questionnaires to all registered nurses on your ward.
4. If there are recently qualified nurses on your ward, you could take part in this study by being interviewed for about 20-30 minutes.

If you are happy to support my study, or if you have any queries please send an email to the following address [Redacted] by 13/11/2009. I am very happy to come and see you to discuss further at your office if you could spare me some time.

I very much appreciate your help.

Yours sincerely

Noriko Tanishima
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Appendix XIX: Remind Letter for RQNs Interviews (Part 1 Scotland)



Staff Nurse
[Redacted]

Reminder Letter

**A cross cultural study of strategies to maintain the nursing workforce
with a particular focus on recently qualified registered nurses.**

Dear [Redacted]

This is a reminder letter about being interviewed regarding your involvement in 'Flying Start' and/or 'Early Clinical Career Fellowships'.

About couple weeks ago an interview recruitment package was given to you, asking if you would consider being interviewed about your perceptions and opinions regarding 'Flying Start' and/or 'Early Clinical Career Fellowships'.

If you have already volunteered to be interviewed, please accept our thanks.

If not, then please can you consider being interviewed for about 30 minutes at your ward. If you are happy to speak to me, please contact me via email ([Redacted]) or phone ([Redacted]).

We are grateful for your help, as your opinion and perception will help us to identify the impact of government policies related to recently qualified nurses in the critical care/high dependency nursing workforce in Scotland.

If you have not received an interview recruitment package, or if you have any questions about this study, please do not hesitate to contact me on the following contact details.

Yours sincerely

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Email: [Redacted]

Appendix XX : Reminder Letter for Questionnaires (Part 1 Scotland)



Dear Staff Nurse

Reminder Letter

A cross cultural study of strategies to maintain the nursing workforce with a particular focus on recently qualified registered nurses.

This is a reminder letter about a questionnaire which was distributed to you couple of weeks ago.

About two weeks ago a questionnaire was given to you, asking about your perceptions about workplace change and your experiences of being a recently qualified nurse.

If you have already completed and returned the questionnaire, please accept our thanks.

If not, then please can you fill out the questionnaire and return it to us by 20/12/2009.

We are grateful for your help, as your response will help us to identify the impact of government policies related to recently qualified nurses in the critical care/high dependency nursing workforce in Scotland.

If you need another copy, or if you have any questions about this study, please do not hesitate to contact me.

Yours sincerely

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Email: [REDACTED]

[REDACTED]
Nursing & Health Care
Faculty of Medicine
University of Glasgow
59 Oakfield Avenue
Glasgow G12 8LL

Tel: [REDACTED]
Email: [REDACTED]

Appendix XXI: Field Note Template

Field Note of interview

Interviewee	Date and Time
Length of the interview	Place
Overall opinion of interview	
My performance	
Anything uncomfortable	
Unexpected findings	
Possible questions for the next interview	
Things should be changed by the next interview	
Issues and concerns need to be solved by the next interview	
Suggested person I should talk	

Anything else to note some jargon I did not understand. NHS history need to be checked.

Appendix XXII: Interview Guide for Nurse Managers (Part 2 Japan)-Translated-



University of Glasgow Nursing & Health Care

Interview Guide: Questions to Nursing Staff at the Management Level

A Survey for a Japan-UK Comparative Study on “Policies to secure new nursing personnel, make them settle down there and improve the nursing personnel’s quality”

Recently, hospital nurses' role in offering safe and reliable medical services has been increasingly significant. Therefore, Ministry of Health, Labour and Welfare has made various attempts regarding the improvement of nursing care and the retention of sufficient number of nurses, such as reworking of pre-registration nursing education, in order to keep producing quality nursing care. Then, I would like to ask you about your opinions on these attempts made by the government.

Q1: There has been various efforts on the government's part in helping secure and retain sufficient number of nurses as well as improving their service. How would you evaluate these recent attempts by the government?

Q2: What kinds of effects do you expect from the government's efforts in securing and retaining sufficient number of nurses, as well as improving their services?

Q3: I imagine there have been several changes in the working environment of nursing brought about by the aforementioned government's attempts. If you could think of any of the changes taking place in your hospital, please give specific examples.

Q4: Are there any apprehensions on your part about the government's recent policies on the retention of nurses and improvement of nursing care? If there are, please express your concern.

Q5: What do you think is the important factor to achieve the goal of these government's attempts?

Job separations of new nursing personnel at an early stage of the career and improvement in their quality have been regarded as great challenges for the past few years. Thus, I would like to ask you how your hospital and/or ward have been addressing these challenges.

Q6: A bill for the partial revision of the “Nurse Provision Act” was enacted as well as the bill for revising the “Public Health Nurses, Midwives and Nurses Act” in July 2009. Due to this revision, employers have to make efforts to establish the post-graduation clinical training system. Has your hospital/ward newly started some sort of training system or activities with this revision? Also, is there any big change with your clinical practice after this revision?

Q7: It is expected that the post-graduation training system will improve nurses' practical expertise while preventing them from leaving work at an early stage of their career. How effective do you think the post-graduation training system is?

Q8: I suppose that these government attempts bring various changes to new nursing personnel. Do you see any changes?

Q9: What is your hospital doing for preventing early job separations of new nursing personnel and improving the quality?

Q10: Is there any concern or challenge when conducting these activities for new nursing personnel at your hospital? Could you elaborate it, if any?

Q11: Aside from the training system for new nursing staff, what else do you think is necessary for improving nurses' practical expertise and preventing them from leaving work at an early stage of their career?

Q12: What do you think about the Scottish government attempts to prevent early job separation at the new nursing personnel?

Appendix XXIII: Interview Guide for RQNs (Part 2 Japan)-Translated-



Interview Guide: Questions for New Nursing Personnel A Survey for a Japan-UK Comparative Study on “Policies to secure nursing personnel and improve the nursing personnel’s quality”

I think it was extremely hard for you to adapt to clinical practice, be self-aware as a medical professional and carry out your duties as a nurse. I would like to ask you about your experience as a novice nursing staff.

Q1: How have you felt about your work as a novice nurse so far?

Q2: I assume that your social role changed from a nursing student to a nurse when starting your career. What do you see as an important factor when a nurse adapts to clinical practice?

Q3: Please let me know briefly about various support which a hospital you work has provided you after your career start up to the present for adapting to clinical practice as a nurse.

Q4: What support did you expect to receive from the hospital before starting your career as a nurse?

Q5: How happy are you with support provided by a hospital in order to adapt to clinical practice as a nurse? Why is that?

Q6: Please specify if the support provided by the hospital helped you a lot in clinical practice.

Q7: Please let me know if there is any concern or anything to be improved about support which the hospital provided you after your career start up to the present. Further, please also tell me the reason(s).

Q8: What do you see as a factor/factors to help you or interrupt you to adapt to clinical practice as a new nurse?

Q9: Is there anything else you would like to talk about your experience as a new nurse?

Appendix XXIV; Consent Form (Part 2 Japan)-Translated-



A Japan-UK Comparative Study on 'Policies to secure the new nursing personnel, make them settle down there and improve the nursing personnel's quality'

Consent form for study participation and cooperation

Researcher: Noriko Tanishima

Please read the following sentences and sign your surname in the blank box if you agree with the contents.

1. I have read and understood the instruction of Japan-UK Comparative Study on 'Policies to secure the new nursing personnel, make them settle down there and improve the nursing personnel's quality'. I have also been given opportunities to ask any questions regarding the contents of the instruction if required. ☐
2. I have understood that the participation and cooperation to this study is based on my free will, and in any case, that I can refuse it without informing the reason to the researcher. ☐
3. I permit that the researcher would use a digital recorder at the interviews and announce the recordings, with anonymity, for her/his papers, conference and any other means of presentations. ☐
4. I permit that the researcher would take notes of any contents of the interviews and announce the recordings, with anonymity, for her/his papers, conference and any other means of presentations ☐
5. I agree that I will participate and cooperate the above study. ☐

Participant

date

sign

.....

Witness

date

sign

.....

Researcher

date

sign

.....

This consent form will be kept one by the participant and one by the researcher.

Appendix XXV: Questionnaire (part 2 Japan)-Translated-



A cross cultural study of strategies to maintain the nursing workforce with a particular focus on recently qualified registered nurses

Questionnaire

- It takes approx. 15~20 minutes to complete all of question items in this questionnaire.
- This questionnaire is fully anonymous and any specific individual and group will not at any time be identified. Questionnaires you submitted will be kept very carefully and discarded when the research has been completed. Therefore, people surveyed shall not be troubled. Further, we shall not contact you again after the survey.
- Please let us know at the contact information shown in the last page of this questionnaire should you have any questions when you fill out this questionnaire.
- If you want to get the summary of the research findings by e-mail, please take a moment to let us know at the contact information shown in the last page of this questionnaire so that we can send it to you via e-mail after the research has been completed. Further, you can find the research paper (written in English) on the following website of Library, University of Glasgow in the UK.

Library, University of Glasgow,
Hillhead Street, Glasgow G12 8QE,
Scotland, UK
tel: +44 (0)141 330 6704
email: library@lib.gla.ac.uk
Web: <http://www.lib.gla.ac.uk/>

Attribute & Employment Situation

Please tick ☒ the answer that you see the most appropriate in each question.

1. Which of the following is your gender?

- ☐ Female
☐ Male

2. How long have you worked for your current workplace so far?

- ☐ Less than 12 months
☐ 1~5 years
☐ 6~10 years
☐ 11~15 years
☐ 16~20 years
☐ Over 20 years

3. Which of the following is your final education?

- ☐ Graduated from a nursing vocational school
☐ Graduated from 2-year nursing college
☐ Graduated from 3-year nursing college
☐ Graduated from 4-year college
☐ Completed master's degree programme
☐ Completed doctoral programme
☐ Others (Please specify the details.)

4. How long have you worked as a nurse so far?

- | | |
|--|--|
| <input type="checkbox"/> Less than 2 years
<input type="checkbox"/> 2~ 5 years
<input type="checkbox"/> 6-10 years
<input type="checkbox"/> 11~15 years
<input type="checkbox"/> 16~20 years
<input type="checkbox"/> Over 20 years | <div style="display: inline-block; vertical-align: middle;">→ Please answer questions in section 2&3</div> <div style="display: inline-block; vertical-align: middle; border-left: 1px solid black; height: 100px; margin: 0 10px;"></div> <div style="display: inline-block; vertical-align: middle;">→ Please answer questions in section 1&3.</div> |
|--|--|

Section1: People who have worked as a nurse for more than 2 years

About work

Regarding the following items, how has the situation around you changed during the past 12 months? Please tick ☒ the box with the most appropriate answer.

How have the following items changed during the past 12 months?	Significantly decreased	Slightly decreased	No change	Slightly increased	Significantly increased
5. A sense of accomplishment that I get from working					
6. Work-related stress					
7. My value as an employee					
8. Morale and motivation of staff at my workplace					
9. My daily workload					
10. Nursing-care quality provided	Significantly deteriorated	Slightly deteriorated	No change	Slightly improved	Significantly improved
11. My available resources in provided nursing care					
12. Your job satisfaction					
13. A sense of reassurance that your current position will be guaranteed					
14. Standard of Nursing staff assignment at your workplace					
15. Satisfaction with your current working environment					
16. Satisfaction with your salary					
17 Length of time you spend for caring your patients directly.					
18. Quality of communication with the Director of Nursing and the ,Ward Manager	Significantly deteriorated	Slightly deteriorated	No change	Slightly improved	Significantly improved
19. Work responsibilities					
20 Length of time that I spend for communicating verbally with your patients.					

* Question 5-20 developed by Nolan (1998) are used based on the permission by the author to use them for this research.

Section1: People who have worked as a nurse for more than 2 years

21. What is the level of your understanding of governmental policies for practical medical nursing? Please tick (☒) the most relevant category below.

- ☐ Very high
- ☐ High
- ☐ To certain extent
- ☐ A little
- ☐ None

22. How much do you know about laws, measures and policies established by the Japanese government and local governments about increasing and securing nursing personnel as well as improving the quality of nursing personnel? Please tick ☒ the answer that you see the most appropriate.

- ☐ I fully understand about it.
- ☐ I know a lot about it.
- ☐ I know about it to some extent.
- ☐ I know a few things about it.
- ☐ I do not know about it at all.

23. How much do you think medical laws, measures and policies established by Ministry of Health, Labour and Welfare influence your clinical practice? Please tick ☒ the answer that you see appropriate.

- ☐ They have got a great influence on it.
- ☐ They influence a lot.
- ☐ They influence to some extent.
- ☐ They influence a little.
- ☐ They do not influence at all.

Section 2: Novice Nurses, People who have worked as a nurse for less than 2 years

About Experience as a Novice Nurse

24. How often did you encounter difficulties in adapting to clinical practice as a nurse?
Please tick ☒ the answer that you see the most appropriate.

- ☐ I always encountered difficulties.
☐ I sometimes encountered difficulties.
☐ I encountered difficulties only occasionally.
☐ I have never encountered any difficulties.

How much did the following factors hinder your adaptation to clinical practice as a nurse?
Please tick ☒ the box with the most appropriate answer.

How much did the following factors hinder your adaptation to clinical case as a nurse?	Strongly hindered	Hindered to a large extent.	Hindered to some extent.	Hindered a little.	Nothing to do with the factor
25. Non-acquirement of the basics of nursing care skills.					
26 Lack of expertise and skills necessary in your division					
27. Lack of skills to have communication with patients and their families as well as your co-workers					
28. Lack of opportunities to have enough training at work					
29. Lack of support from co-workers at work					
30. Lack of support from family and friends					
31. Lack of nurse as a role model at work who helps increasing your self-awareness as a professional					
32. Non-favourable feedbacks or lack of feedbacks from your colleagues.					
33 Non-favourable feedbacks or lack of feedbacks from your patients or their family.					
34. The gap between work as a nurse which you imagined before being employed and work you are actually doing as a nurse					
35. Dissatisfaction with work, concerns for work and dissatisfaction with your work environment (e.g. too much workload, fears that you could cause medical accidents and irregular work hours)					
36. Concerns for your own ability as a nurse (e.g. Worried that you are not suitable for nursing)					

* Factor 25~36 are extracted from the field survey conducted by Japanese Nursing Association focusing on early job separation of nursing staff who started working from 2004

Section 2: Novice Nurses, People who have worked as a nurse for less than 2 years

37. Along with the above-stated factors, is there any factor which hindered your adaptation to clinical practice as a nurse? Please describe it specifically if any.

38. What made your adaptation to clinical practice as a nurse easy? Please describe it specifically.

(e.g. Support from your family, Encouragement from your co-workers)

39. Please describe support which your current workplace provided or has been providing to you since you started working there in order to help you adapt to clinical practice as a nurse.

(e.g. Preceptorship, Regular hospital training programme, Study session in a hospital ward)

40. What is the level of satisfaction in the support you have received from your workplace in order to adapt to the clinical practice? Please tick (☒) the most relevant category below.

- ☐ Very high
- ☐ High
- ☐ Neither
- ☐ Little
- ☐ Very little

41 In what extent did the support you have received from your workplace in order to adapt to the clinical practice helped you? Please tick (☒) the most relevant category below.

- ☐ Very helpful
- ☐ Helpful
- ☐ To certain extent
- ☐ Helped a little
- ☐ Did not help at all

Section 2: Novice Nurses, People who have worked as a nurse for less than 2 years

42. Finally, when you sum up your experience as a novice nurse in a single phrase, which of the following best describes how you feel? Please tick ☒ the answer that you see the most appropriate.

- ☐ Very good experience
- ☐ Good experience
- ☐ Neither good nor bad
- ☐ Bad experience
- ☐ Very bad experience

Section 3: All Nurses

About your Working Environment

Regarding the following questions, which answer best describes your current work condition? Please tick ☒ the box with the most appropriate answer.

	Not applicable at all	Not applicable	Applicable	Absolutely applicable
43. There is an appropriate support system which allows nurses to have time to spend time with patients under their charge.				
44. Doctors and nurses develop good working relationships.				
45. Supervisors are cooperative toward nurses.				
46. The workplace makes efforts to promote staff training programmes and continued education programmes for nurses.				
47. There are opportunities to develop career and/or utilise the clinical ladder.				
48. Nurses as staff have got opportunity to participate in the decision-making process for various policies.				
49. Supervisors take staff's mistakes as learning opportunities rather than criticising them.				
50. You have got enough time and opportunities to talk about issues related to patient care with other nurses.				
51. A sufficient number of nurses are staffed in order to provide high-quality patient care.				
52. The Ward Manager is a good manager as well as a good leader.				
53. The staff can see clearly what the senior nurse is doing and feel that she/he is very close to you.				
54. There are a sufficient number of staff to get through with works.				
55. When you perform your task very well, it is recognised by other people and you receive compliments on your achievement.				
56. The department of management in the hospital requests high-level nursing care.				
57. The Director of Nursing has got equal power and authority with top management of the hospital.				

Section 3: All Nurses

	Not applicable at all	Not applicable	Applicable	Absolutely applicable
58. There is a strong team work between nurse and doctor.				
59. There are opportunities to be promoted or improve yourself as a nurse.				
60. The principles of nursing spread through places where nursing care is provided				
61. You work with nurses who have got excellent clinical ability.				
62. The Ward Manager supports the decision making of nursing staff even if it would lead to a confrontation with doctors.				
63. Top management of the hospital listens to opinions of staff and respond to them.				
64. There is an active quality assurance programme.				
65. Nursing staff get deeply involved in the hospital's management. (e.g. the participation in a committee which decide the hospital's policies)				
66. Nurses work in cooperation with doctors for medical practice.				
67. There is a preceptor programmes for newly-employed nurses.				
68. Nursing care is not based on the medical model but the nursing model.				
69. Nursing staff have got opportunities to take part in committees of the hospital or the nursing department.				
70. The Ward Manager consults with staff about problems that come up daily and procedures related to ward management.				
71. Patient-care plans for all of patients are described and reviewed on a constant basis.				
72. In order to provide continuous nursing care, you are in charge of certain patients. (For example, one nurse looks after a same patient throughout the day.)				

* *Question 43-72 were developed by Aiken and uses NWI-R modified by Lake.

Section 3: All Nurses

About your future career perspective

73. How often did you consider leaving your current workplace during the past 12 months? Please tick ☒ the answer that you see the most appropriate.

- ☐ Never considered.
- ☐ Considered several times during the past 12 months.
- ☐ Considered several times a month.
- ☐ Considered several times a week.
- ☐ Considered every day.

74. How often did you consider giving up pursuing a career as a nurse during the past 12 months? Please tick ☒ the answer that you see the most appropriate.

- ☐ Never considered.
- ☐ Considered several times during the past 12 months.
- ☐ Considered several times a month.
- ☐ Considered several times a week.
- ☐ Considered every day.

Thank you very much for your cooperation.

Noriko Tanishima

PhD Candidate
Nursing & Health Care
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Appendix XXVI: Initial Contact Letter to Director of Nursing (Japanese)



University of Glasgow Nursing & Health Care

平成22年5月10日

[Redacted]

私はイギリスのグラスゴー大学で看護学の博士課程に在籍しております、谷嶋典子と申します。現在、看護労働力の確保と質の向上に関する政策とその影響について研究をしております。特に、新人看護師の確保と定着、質の向上に焦点をあて、政策の影響、効果について、日本とイギリスで比較調査を行っております。

この度は、私の研究へのご協力をお願いしたくお手紙を差し上げました。看護職員の確保と定着、その質の向上に関連する政策や施策、また新人看護職員の確保と定着、その質の向上に関連した政策や施策についてご意見を伺いたいと考えております。

大変お忙しいかとは存じますが、良いお返事をお待ちしております。よろしくお願いいたします。

お話をさせていただきたい内容の概要、研究計画書、研究の説明書を同封させていただきます。

谷嶋典子

日本での連絡先

住所：

[Redacted]

電話：

[Redacted]

携帯：

[Redacted]

メールアドレス：

[Redacted]

Initial Contact Letter to Director of Nursing (Translation)

10/05/2010

Dear Director of Nursing

Hello. My name is Noriko Tanishima. I am a PhD student at University of Glasgow in UK. Currently I am conducting a comparison study between Scotland and Japan to investigate the government policies to maintain the nursing workforce and their impact.

I am writing this letter to seek your help for this study. I would like to have some advices and help on my project which is focusing on the government policies related to recently qualified nurses.

I would very much appreciate if you could spare me some time for this matter. I am looking forward to hear from you.

I have enclosed a study protocol for your information.

Noriko Tanishima

Contact Details in Japan

Address: [REDACTED]

Line Phone [REDACTED]

Mobile Phone [REDACTED]

Email: [REDACTED]

Appendix XXVII: Ethics and management Approval from Japanese Hospital 1

研 究 承 諾 書

平成 22 年 5 月 9 日

申請者 谷嶋典子殿

研究課題：日英（スコットランド）における「新人看護職員の確保と定着、その質の向上
のための政策」についての比較研究

A cross cultural study of strategies to maintain the nursing workforce with a particular
focus on recently qualified registered nurses

所属機関：University of Glasgow, Faculty of Medicine, Nursing&Healthcare

上記の者が、上記研究課題を当院看護部所属の職員を対象として研究すること
を承諾します。

平成 22 年 5 月 9 日

〒650-0017
神戸市中央区楠町7丁目5番2号
神戸大学医学部附属病院

看護部長 大島 敏子



Appendix XXVIII: Ethics and management Approval from Japanese Hospital 2

研 究 承 諾 書

平成 22 年 5 月 9 日

申請者 谷嶋典子殿

研究課題：日英（スコットランド）における「新人看護職員の確保と定着、その質の向上のための政策」についての比較研究

A cross cultural study of strategies to maintain the nursing workforce with a particular focus on recently qualified registered nurses

所属機関：University of Glasgow, Faculty of Medicine, Nursing&Healthcare

上記の者が、上記研究課題を当院看護部所属の職員を対象として研究することを承諾します。

平成 22 年 5 月 9 日

看護部長 中野悦子 

Appendix XXIX: Study Protocol (Part 2 Japan)



University of Glasgow
Nursing & Health Care

研究計画書

研究課題

日英（スコットランド）における「新人看護職員の確保と定着、その質の向上のための政策」についての比較研究

研究目的

この研究は、新人看護職員の確保と定着、その質の向上のための政策や施策、各病院におけるその影響や効果を明らかにし、またそれらについて、日本とイギリスを比較し検討するものです。その結果、両国の看護職員に関する新たな政策作成過程において、新人看護師の確保と定着に新たなアプローチ法を提案することを目的とする。

具体的研究課題

1. 日英の新人看護職員の確保と維持、その質向上のための政策を特定する。
2. 1で特定した政策が病院勤務の看護師にどの程度認知されているか明らかにする。
3. 1で特定した政策による具体的な成果、影響を明らかにする。
4. 1で特定した政策で意図しなかった結果の有無を明らかにする。
5. 以上の課題を明確にすることで、看護職員の確保と定着、その質の向上に貢献する新たな提案をする。

研究課題の背景とその意義

日本とイギリスにおいて、人口の高齢化、医療技術の高度化による疾病構造の変化、医療費の増大、出生率の低下に伴う医療労働人口の減少など、日英の医療を取り巻く課題は共通するところがある。看護職員の確保と定着、その質の向上は、医療システムを円滑に効率的に運営する上で、また安全で公平な医療をすべての国民に提供するために、特に重要な課題である。新人看護職員の早期離職や看護の質は、日本だけでなくイギリスにおいても、問題視されており、両国ともに新人看護師を対象とした取り組みが行われている。しかし、両国ともそれらの政策について具体的な評価や結果についての研究が十分になされておらず、地方や各病院における政策の評価や実施状況、看護師への直接的な影響などについては、不明瞭なところが多い。この研究を通し、日英における政策と、地方自治体、各病院における政策実施状況を比較調査する事で両国の類似点、相違点を明らかにし、その効果や影響について評価したい。そして、この結果をもとに、今後の両国の新人看護職員に関する政策評価や新たな政策作成過程において、新たなアプローチ法を提案し、それが新人看護師の確保と更なる質の向上へ貢献したいと考える。

研究方法

この研究は、2部構成とし、第1部はスコットランド、グラスゴーで行われ、第2部は日本、神戸市で行われる。日本での研究は2フェーズに分けられ、第1フェーズは看護基礎教育に関わるもの、または看護政策に精通する大学教育者とのインタビュー、第2段階は看護管理者、新人看護教育に携わる看護師、新人看護師とのインタビューと看護師へのアンケート調査とする。インタビューとアンケート調査によって収集された情報は、SPSS と Nvivo をもちいて、分析する。

研究対象

研究対象と調査標本数

第1フェーズ

インタビュー

- 看護基礎教育に関わる大学教育者 (n=4-5)
- 看護政策に精通する大学教育者 (n=1-2)

第2フェーズ

- 看護管理者（看護部長 看護副部長など） (n=2-3)
- 新人看護師教育に携わるもの（OJT 委員） (n=2-3)
- ICU/CCU/HDU に勤務する看護師長および看護副師長、または主任 (n=10)
- 新人看護師（臨床経験 2 年以下） (n = 15)

アンケート対象者

- ICU/CCU・HDU に勤務する看護師 (n=200)

情報収集方法

第1 フェーズ

情報収集は看護基礎教育に関わるもの、または看護政策に精通する大学教育者とのインタビューを行う。看護職員の確保と定着、その質の向上に関連する政策や施策、また新人看護職員の確保と定着、その質の向上に関連した政策や施策について意見や、その影響、また課題等について30分程度のインタビューを行う。

第2 フェーズ

情報収集は看護管理者、および看護教育者へのインタビューと看護師へのアンケート用紙を用いて行う。

看護管理者、新人看護師教育に携わる者に対しては、新人看護職員を対象とした政策に対する意見、見解、その評価、実際の臨床現場における影響などについて30分程度のインタビューを行う。新人看護師に対しては、就職後の看護師としての体験、また職場環境への適応を困難にした要因や容易にした要因について30分程度のインタビューを行う。また、看護師を対象として、この1年間の職場環境の変化、また職場環境について、離職の意思についてのアンケートを行う。

インタビューは、参加者の同意のもと録音する。アンケート用紙は、研究説明書、返信用封筒を同封され、看護師へ直接配布される。看護師は4週間以内に、アンケート用紙の解答を研究者へ返信する。研究への参加同意はアンケート用紙の返信をもって得られたこととする。病棟師長の承認がある場合、研究者が病棟会などに参加し、研究への参加呼びかけを行う。

研究および倫理承認と倫理的配慮

この研究では個人が特定できる情報は収集しない。この研究によって得られた情報は研究者のみが使用し、厳重に保管する。これらの情報は、研究以外の目的に使用されることはなく、研究結果を論文や学会発表またはその他の方法で公表する場合は匿名性を厳守する。録音されたインタビュー、返信されたアンケート用紙は研究終了時に消去、破棄される。この研究への参加協力は自由意志によって行われる。意思決定の際に必要な情報は、研究説明書によって提供し、研究参加同意を得る。研究への参加を同意した場合であっても、途中で参加を取りやめることができる。

研究結果の公表について

研究参加協力者には、研究終了後に研究結果サマリーを郵送またはメールにて送付する。博士論文はグラスゴー大学図書館にて閲覧可能となる。

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Appendix XXX: Participant Information Sheet for Interviews with managers (Part 2 Japan)



日英（スコットランド）における
「新人看護職員の確保と定着、その質の向上のための政策」についての比較研究説明書

この度は、あなたに研究への参加・協力をお願いしたくお手紙差し上げました。この研究は、下記の目的で行うものです。研究の趣旨をご理解の上、ご協力くださるかどうにお決めください。ご不明な点がございましたら、お手数ですが下記連絡先まで問い合わせください。

この研究は、グラスゴー大学の博士課程を履修する学生の谷嶋典子の博士論文プロジェクトであり、同大学スミス教授により指導を受けて行われています。

記

1. 研究の目的

この研究は、新人看護職員の確保と定着、その質の向上のための政策や施策、各病院におけるその影響や効果を明らかにし、またそれらについて、日本とイギリスを比較し検討するものです。その結果、両国の看護職員に関する新たな政策作成過程において、新人看護師の確保と定着に新たなアプローチ法を提案することを目的としています。

2. 研究の背景とその意義

日本とイギリス（スコットランド）における、人口の高齢化、医療技術の高度化による疾病構造の変化、医療費の増大、出生率の低下に伴う医療労働人口の減少など、日英の医療を取り巻く課題は共通するところがあります。看護職員の確保と定着、その質の向上は、医療システムを円滑に効率的に運営する上で、また安全で公平な医療をすべての国民に提供するために、特に重要な課題です。新人看護職員の早期離職や看護の質は、日本だけでなくイギリスにおいても、問題視されており、両国ともに新人看護師を対象とした取り組みが行われていますが、両国ともそれらの政策について具体的な評価や結果についての研究が十分になされておらず、地方や各病院における政策の評価や実施状況、看護師への直接的な影響などについては、不明瞭なところが多いのが現状です。この研究を通し、日英における政策と、地方自治体、各病院における政策実施状況を比較調査する事で両国の類似点、相違点を明らかにし、その効果や影響について評価したいと考えています。そして、この結果をもとに、今後の両国の新人看護職員に関する政策評価や新たな政策作成過程において、新たなアプローチ法を提案し、それが新人看護師の確保と更なる質の向上へ貢献したいと考えます。

3. あなたへ研究へのご協力をお願いする理由

看護職員の確保と定着、その質の向上に関連する政策や施策、また新人看護職員の確保と定着、その質の向上に関連した政策や施策についてあなたのご意見を伺いたいと考えております。

4. 研究への協力内容

この研究への参加・協力は、あなたとの30分程度のインタビューをお願いするものです。インタビューでお聞きする質問については、別紙をご参照ください。インタビューは、あなたのご都合に合わせ日時、インタビューを行う場所を決定させていただきます。通常インタビューは、あなたの職場でプライバシーの確保ができるスペースにて行います。インタビュー内容は、あなたの許可を得てデジタルレコーダーにより録音され、研究終了時までコンピューターに保存されます。インタビュー内容の録音を拒否する事もできます。

5. 研究へのご協力の自由意志について

この研究へのご協力はお断りなることもできます。お断りになっても、あなたが不利益をこうむる事はありません。また、この研究への協力を同意した場合であっても、いつでも途中でやめることができます。そのことで、不利益をこうむる事はありません。遠慮なく、その旨を研究者へお伝えください。

6. あなたから提供された情報の保護について

この研究にご協力いただける場合、プライバシーは堅く守ります。また研究を通して特定の個人や団体が特定できる情報は収集いたしません。研究によって得られた情報、および結果は研究以外の目的に使用することはありません。録音されたインタビューは、研究者のみがアクセスできる個人所有のコンピューターに保存し、分析を行います。これらの情報は、研究終了時まで保存された後、消去・破棄されます。研究結果を論文や学会発表、またその他の方法で公表する場合は、匿名性を守ります。

7. 研究に参加・協力することによって期待される利益について

この研究に参加・協力することによって、あなたが直接受け取ることのできる利益はありません。しかしながら、この研究結果が新人看護師の確保と定着、その質の向上に向けた取り組みに新たなアプローチ法を提案できる事を期待しています。また、その取り組みの結果が、看護師の労働環境の改善と看護ケアの質の向上につながることを期待しております。

8. 研究に参加・協力することによって起こりうる不利益について

この研究に参加・協力することによって、あなたが直接不利益や危害を受けることはありません。ただし、インタビューには貴重なお時間を 30 分程度さいていただきますことをご了承ください。

9. 研究結果の公表方法について

この研究を基にした博士論文（英文）はグラスゴー大学図書館にて閲覧可能となります。閲覧を希望される場合は、お手数ですがグラスゴー大学図書館のホームページ (library@lib.gla.ac.uk) を参照ください。また、研究結果をお知りになりたい場合は、研究者までご連絡ください。研究結果の要約を E メールにて送信させていただきます。

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お手数ですが、6月30日までに下記の研究者の連絡先まで、メールまたは電話にてその旨をお伝えください。その後、インタビュー日時の詳細について再度連絡差し上げます。同意書はインタビュー開始時に回収させていただきます。

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Appendix XXXI: Participant Information Sheet for Interviews with RQNs (Part 2 Japan)



日英（スコットランド）における 「新人看護職員の確保と定着、その質の向上のための政策」についての比較研究説明書

この度は、あなたに研究への参加・協力をお願いしたくお手紙差し上げました。この研究は、下記の目的で行うものです。研究の趣旨をご理解の上、ご協力くださるかどうにお決めください。ご不明な点がございましたら、お手数ですが下記連絡先まで問い合わせください。

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記

1. 研究の目的

この研究は、新人看護職員の確保と定着、その質の向上のための政策や施策、各病院におけるその影響や効果を明らかにし、またそれらについて、日本とイギリスを比較し検討するものです。その結果、両国の看護職員に関する新たな政策作成過程において、新人看護師の確保と定着に新たなアプローチ法を提案することを目的としています。

2. 研究の背景とその意義

日本とイギリス（スコットランド）における、人口の高齢化、医療技術の高度化による疾病構造の変化、医療費の増大、出生率の低下に伴う医療労働人口の減少など、日英の医療を取り巻く課題は共通するところがあります。看護職員の確保と定着、その質の向上は、医療システムを円滑に効率的に運営する上で、また安全で公平な医療をすべての国民に提供するために、特に重要な課題です。新人看護職員の早期離職や看護の質は、日本だけでなくイギリスにおいても、問題視されており、両国ともに新人看護師を対象とした取り組みが行われていますが、両国ともそれらの政策について具体的な評価や結果についての研究が十分になされておらず、地方や各病院における政策の評価や実施状況、看護師への直接的な影響などについては、不明瞭なところが多いのが現状です。この研究を通し、日英における政策と、地方自治体、各病院における政策実施状況を比較調査する事で両国の類似点、相違点を明らかにし、その効果や影響について評価したいと考えています。そして、この結果をもとに、今後の両国の新人看護職員に関する政策評価や新たな政策作成過程において、新たなアプローチ法を提案し、それが新人看護師の確保と更なる質の向上へ貢献したいと考えます。

3. あなたへ研究へのご協力をお願いする理由

あなたの新人看護師としての経験について伺いたいと考えております。

4. 研究への協力内容

この研究への参加・協力は、あなたとの30分程度のインタビューをお願いするものです。インタビューでお聞きする質問については、別紙をご参照ください。インタビューは、あなたのご都合に合わせて日時、インタビューを行う場所を決定させていただきます。通常インタビューは、あなたの職場でプライバシーの確保ができるスペースにて行います。インタビュー内容は、あなたの許可を得てデジタルレコーダーにより録音され、研究終了時までコンピューターに保存されます。インタビュー内容の録音を拒否する事もできます。

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Appendix XXXII: Participant Information Sheet for Questionnaires (Part 2 Japan)



日英（スコットランド）における
「新人看護職員の確保と定着、その質の向上のための政策」についての比較研究説明書

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2. 研究の背景とその意義

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3. あなたへ研究へのご協力をお願いする理由

新人看護職員の確保と定着、その質の向上のための政策や施策の実際の効果や影響を明らかにするために、病院で勤務されている看護師の方々にアンケートにお答えいただき、臨床現場の実情を調査したいと考えております。

4. 研究へのご協力内容

この研究へのご協力は、アンケートに回答をお願いするものです。回答していただくのに約 20 分程度かかります。

5. 研究へご協力の自由意志について

この研究への参加・協力はお断りなることもできます。お断りになっても、あなたが不利益をこうむる事はありません。

6. 研究へのご協力の拒否権について

この研究へのご協力は、アンケート用紙への回答とその研究者への返信をもって、同意されたこととさせていただきます。一度、研究者が収集したアンケート用紙は特定の個人を確定することは不可能であり、アンケート収集後の、ご辞退は不可能となります。

7. あなたから提供された情報の保護について

この研究にご協力いただける場合、プライバシーは堅く守ります。また研究を通して特定の個人や団体が特定できる情報は収集いたしません。研究によって得られた情報、および結果は研究以外の目的に使用することはありません。回収されたアンケート用紙は、研究者のみが開閉できる鍵のついた保管書棚に保存します。またアンケートから収集されたデータは暗号化され、個人所有のコンピューターに保存し、分析を行います。これらの情報は、研究終了時まで保存された後、消去・破棄します。研究結果を論文や学会発表、そのほかの方法で公表する場合は、匿名性を守ります。

8. 研究に参加・協力することによって期待される利益について

この研究に参加・協力することによって、あなたが直接受け取ることのできる利益はありません。しかしながら、この研究結果が新人看護師の確保と定着、その質の向上に向けた取り組みに新たなアプローチ法を提案できる事を期待しています。また、その取り組みの結果が、看護師の労働環境の改善と看護ケアの質の向上につながることを期待しております。

9. 研究に参加・協力することによって起こりうる不利益について

この研究に参加・協力することによって、あなたが直接不利益や危害を受けることはありません。ただし、アンケートに回答していただけるのに、貴重なお時間を約20分程度さいいただきますことをご了承ください。

10. 研究結果の公表方法について

この研究を基にした博士論文（英文）はグラスゴー大学図書館にて閲覧可能となります。閲覧を希望される場合は、お手数ですがグラスゴー大学図書館のホームページ (library@lib.gla.ac.uk) を参照ください。また、研究結果をお知りになりたい場合は、研究者までご連絡ください。研究結果の要約をEメールにて送信させていただきます。

11. 研究への参加・協力を了承してくださる場合

お手数ですが、6月30日までにアンケートを回答のうえ、病棟にある回収ボックスへ投函してください。

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Appendix XXXIII: Interview Guide for Nurse Managers (Part 2 Japan)



University of Glasgow Nursing & Health Care

インタビューガイド

日英（スコットランド）における
「新人看護職員の確保と定着、その質の向上のための政策」についての比較研究

ここ数年、安全で安心な医療を提供するために看護師の果たす役割が非常に大きくなってきています。厚生労働省でも質の高い看護を提供するために、今後の看護のあり方や、看護基礎教育の見直しなど、看護職員の確保と定着のために様々な取り組みがされてきていると思います。これらの、政府の取り組みに対するあなたのご意見を伺っていききたいと思います。

Q1: 看護師職員の確保と定着、その質の向上に向けて、様々な取り組みがなされていると思いますが、このような政府の取り組みについて、どのようにお考えですか？

Q2: 政府の看護師の確保、質の向上とその定着に向けた取り組みに、どのような効果を期待されていますか？

Q3: これらのこのような政府の取り組みにより、現場でも様々な変化がもたらされていると思いますが、それについて具体的に教えてください。

Q4: 政府の看護師の確保、質の向上とその定着に向けた取り組みについて、なにか懸念されている事がありますか？

Q5: これらの政策や施策の目標を達成するために、重要な要因は何だとお考えですか？

つぎに、新人看護師についていくつか質問します。新人看護師の早期離職やその質の向上は、ここ数年大きな課題となっていると思います。あなたの病院や病棟でどのようにこれらの課題に取り組まれているのかお聞きしたいと思います。

Q6: 平成 21 年 7 月の「保健師助産師看護師法及び看護師等の人材確保の促進に関する法律の一部を改正する法律案」の成立により、卒後臨床研修制度が努力義務として、制度化されました。この制度化により、あなたの病院や病棟で、新たに何らかの研修制度や取り組みが始まりましたか？ この制度化にともない、臨床現場でなにか大きな変化はありましたか？

Q7: 看護師の実践能力の向上や早期離職の防止が期待されている卒後臨床研修制度に対して、あなたはどのような効果を期待されていますか？

Q8: この政府の取り組みは、新人看護師を取り巻く環境にどのような結果をもたらしていますか？

Q9: 現在、あなたの病院では新人看護師の早期離職防止や質の向上を目的としたどのような取り組みがなされていますか？

Q10: 現在、あなたの病院で新人看護師を対象に実施されている取り組みのなかで、懸念されることや課題等がありますか？ またそれはどのようなことですか？

Q11: 新人看護師の実践能力の向上や早期離職の防止のためには、新人看護師研修制度の他にどのような事が必要だと思いますか？

Q12: スコットランドでは、新人看護師対象としたプログラムもあります。これらの取り組みをどう思われますか？

Appendix XXXIV: Interview Guide for RQNs (Part 2 Japan)

University of Glasgow Nursing & Health Care

インタビューガイド 新人看護師の方

日英2国間の「看護職員の確保とその質の向上のための政策」についての比較研究

臨床現場に適応し、医療専門職者としての自覚を持ち、看護師としての職務を果たす事は大変難しい事だったと思います。あなたの、新人看護師としての経験についてお聞きしたいと思います。

Q1: 就職してからこれまで、新人看護師として勤務されてどのように感じられましたか？

Q2: 就職後、看護学生から看護師として、社会的役割が変化したと思います。看護師として、臨床現場に適応していく際に、重要であると思う事は何ですか？

Q3: 看護師として臨床に適応するために、就職されてから現在まで、あなたの勤務されている病院から様々な提供されたサポートについて簡単に教えてください。

Q4: 就職される前、あなたはどのような病院からのサポートを期待していましたか？

Q5: 就職されてから現在まで、あなたが、看護師として臨床現場に適応するために病院から提供されたサポートにどの程度満足されていますか？それはどうしてですか？

Q6: 病院から提供されたサポートが、臨床現場において非常に役立った経験があれば、具体的に教えてください。

Q7: 就職されてから現在まで、病院から提供されたサポートのなかで、懸念されることや、改善点等があれば教えてください。また、その理由も教えてください。

Q8: あなたが新人看護師として臨床現場へ適応を容易にする、または困難にする要因はどのような事だと思いますか？

Q9: あなたの新人看護師としての経験について、他にお話しされたい事はありますか？

Appendix XXXV; Consent Form (Part 2 Japan)



日英（スコットランド）における
「新人看護職員の確保と定着、その質の向上のための政策」についての比較研究
研究参加・協力同意書

研究者：谷嶋典子

下記の文章を読み、その内容に同意されましたら、空欄のなかに苗字を署名してください。

1. 私は、日英2国間の「新人看護職員の確保とその質の向上のための政策」についての比較研究の説明書を読み、その内容を理解しました。また、説明書の内容について疑問があれば、質問できる機会を提供されました。
2. 私は、この研究への参加・協力が私の自由意志に基づいていること、またいかなる時も、研究者に理由を告げることなく研究への参加・協力が辞退できることを理解しました。
3. 私は、研究者がインタビューをデジタルレコーダーで録音し、論文や学会発表、その他の方法で匿名性を守り、公表することを許可します。
4. 私は、研究者がインタビュー内容を紙面に記載し、論文や学会発表、その他の方法で匿名性を守り、公表する事を許可します。
5. 私は、上記の研究に参加・協力することに同意いたします。

参加者

日付

署名

.....
.....

同意書立会人

日付

署名

.....
.....

研究者

日付

署名

.....
.....

この同意書は、コピー1枚を参加者に、もう一枚を研究者が保管いたします。

Appendix XXXVI: Questionnaires (Part 2 Japan)



日英（スコットランド）における
 「新人看護職員の確保と定着、その質の向上のための政策」についての比較研究
 A cross cultural study of strategies to maintain the nursing workforce with a particular focus on
 recently qualified registered nurses

調査質問用紙

- この質問調査票はすべての項目をご解答いただくのに 20 分程度かかります。
- この調査は、無記名形式で行い、特定の個人や団体を特定することはありません。皆様からご解答いただいた質問調査用紙は、厳重に保管され、研究終了時に破棄されます。この調査にご協力いただくことで、皆様にご迷惑がかかることはございません。また、今後こちらから再度ご連絡することはありません。
- 記入にあたって、不明な点がありましたら、最後のページに記載してある連絡先までご連絡ください。
- この研究結果の要約を e-mail にてご希望される場合は、お手数ですが最後のページに記載してある連絡先までその旨をお伝えください。研究終了後、e-mail にて送付させていただきます。また、この研究論文（英文）については下記のイギリス、グラスゴー大学図書館のホームページからも閲覧可能です。

グラスゴー大学図書館 連絡先
 Library, University of Glasgow,
 Hillhead Street, Glasgow G12 8QE,
 Scotland, UK
 tel: +44 (0)141 330 6704
 email: library@lib.gla.ac.uk
 Web: <http://www.lib.gla.ac.uk/>

あなたの属性、雇用状況について

各設問に対して適切であると思われる解答に印☑をつけてください。.

1. あなたの性別は次のうちどれですか?

- ☐ 女性
☐ 男性

2. あなたは現在の職場でどのくらい働かれていますか?

- ☐ 12ヶ月以下
☐ 13ヶ月-5年
☐ 6-10年
☐ 11-15年
☐ 16-20年
☐ 20年以上

3. あなたの最終学歴は次のうちどれですか?

- ☐ 看護専門学校卒業
☐ 2年制看護短期大学卒業
☐ 3年制看護短期大学卒業
☐ 4年制大学卒業
☐ 大学院修士課程終了
☐ 大学院博士課程終了
☐ その他（具体的にご記入ください）

4. 看護師としてどのくらい働いていらっしゃいますか?

- ☐ 2年以下 →5 ページからセクション 2&3 を回答ください。
☐ 2-5 年
☐ 6-10 年
☐ 11-15 年
☐ 16-20 年
☐ 21 年以上
- 3 ページからセクション 1&3 をご回答ください。

セクション1: 看護師としての職歴が2年より長い方々

職務内容について					
以下の各項目について、過去 12 ヶ月の間、あなたの周りの状況がどのように変化しましたか？以下の設問の答えに最も当てはまるところに印 <input checked="" type="checkbox"/> をつけてください。					
過去 12 ヶ月の間に以下の項目はどのように変化しましたか？	非常に減少した	少し減少した	変化なし	少し増加した	非常に増加した
5. 仕事から得られる達成感は					
6. 私の仕事上のストレスは					
7. 私自身の従業員としての価値は					
8. 職場の職員の士気や、やる気は					
9. 私の日々の業務量は					
10. 提供する看護ケアの質は	非常に悪化した	少し悪化した	変化なし	少し改善した	非常に改善した
11. 看護ケアを提供する際、私が利用可能な資源は					
12. 私の仕事に対する満足度は					
13. 私の現在の職位が今後も保証されているという安心感は					
14. 私の職場の看護職員の配置水準は	非常に悪化した	少し悪化した	変化なし	少し改善した	非常に改善した
15. 私の現在の職場環境に対する満足度は					
16. 私の給料に対する満足度は					
17. 患者へ直接看護ケアを提供するのに費やす時間は					
18. 看護部長や看護師長とのコミュニケーションの質は	非常に悪化した	少し悪化した	変化なし	少し改善した	非常に改善した
19. 私の仕事上の責任は					
20. 私が患者と会話に費やす時間は					

*項目 5-20 は、Nolan (1998) により開発され、本研究には著者の使用許可を得ています。

セクション1: 看護師としての職歴が2年より長い方々

21. あなたの医療看護実践に関係すると思われる政府の政策に関してあなたはどの知識がありますか? もっとも適切であると思われる解答に印☑をつけてください。

- ☐ 非常にある。
- ☐ かなりある。
- ☐ ある程度ある。
- ☐ 少しある。
- ☐ まったくない。

22. 看護職員の確保と定着、その質の向上に関する政府の政策に関してあなたはどの程度の知識がありますか? もっとも適切であると思われる解答に印☑をつけてください。

- ☐ 非常にある。
- ☐ かなりある。
- ☐ ある程度ある。
- ☐ 少しある。
- ☐ まったくない。

23. 政府の医療に関する政策は、あなたの臨床現場にどの程度の影響を与えていると思いますか? 適切であると思われる解答に印☑をつけてください。

- ☐ 非常にある。
- ☐ かなりある。
- ☐ ある程度ある。
- ☐ 少しある。
- ☐ まったくない。

セクション3 8ページから回答を続けてください。

セクション 2: 新人看護師、看護師としての職歴が2年以下の方々

新人看護師としての経験について

24. 臨床現場に看護師として適応するのに、現在までに、どのくらいの頻度で困難に遭遇しましたか？もっとも適切であると思われる解答に印☑をつけてください。

- ☐ いつも
☐ たまに
☐ ごくたまに
☐ 困難に遭遇したことはない。

以下に挙げる要因は、あなたが臨床現場へ看護師として適応するをどの程度困難にしましたか？もっとも当てはまるところに印☑をつけてください。

以下の要因が、あなたが臨床現場に看護師として適応するのをどの程度困難にしましたか？	大いに困難にした。	非常に困難にした。	ある程度困難にした。	少し困難にした	全く関係ない
25. 基本的な看護ケア技術の未修得					
26. 配属部署の専門的な知識や技術の不足					
27. 患者やその家族、同僚などとのコミュニケーション技術の欠如					
28. 職場での十分な教育研修の機会の欠如					
29. 職場の同僚からのサポートの欠如					
30. 家族や友人からのサポートの欠如					
31. 職場での、看護師として自分の専門職者としての自覚形成を助けるロールモデルとなる看護師の欠如					
32. 同僚からの好意的でない同僚からのフィードバック、またはフィードバックそのものの欠如					
33. 患者やその家族からの好意的でないフィードバック、またはフィードバックそのものの欠如					
34. 就職前に考えていた看護の仕事と、現在の自分のしている看護の仕事とのギャップ					
35. 仕事への不満や不安、職場環境への不満（業務量が多い。医療事故を起こさないか不安。勤務時間が不規則など）					
36. 看護師としての自分自身の能力への不安（自分は看護師に向いていないのではないか、など）					

* 25-36の要因は、日本看護協会の2004年新卒看護職員の早期離職等実態調査から抽出されている。

セクション 2: 新人看護師、看護師としての職歴が2年以下の方々

37. 以上に挙げた要因のほかに、あなたが臨床現場へ看護師として適応するのを困難にした要因はありますか？あれば具体的に述べてください。(複数回答可)

38. どのようなことが、あなたが臨床現場へ看護師として適応するを容易にしましたか？具体的に述べてください。(複数回答可)

(家族の支え、同僚の励ましなど)

39. 現在の職場で働き始めてから、臨床現場への適応を助けるために職場から提供された、または現在も提供されているサポートを具体的に述べてください。

(プリセプターシップ、定期的な病院研修制度、病棟での勉強会など)

40. 臨床現場への適応を助けるための職場からのサポートに、あなたはどの程度満足していますか？もっとも適切であると思われる解答に印 \square をつけてください。

- ☐ 非常に満足している。
- ☐ 満足している。
- ☐ どちらでもない。
- ☐ 不満足である。
- ☐ 非常に不満足である。

41. 臨床現場への適応を助けるための職場からのサポートとは、あなたにとってどの程度役に立ちましたか？もっとも適切であると思われる解答に印 \square をつけてください。

- ☐ 非常に役に立った。
- ☐ 役に立った。
- ☐ ある程度役に立った。
- ☐ 少し役に立った。
- ☐ まったく、役に立たなかった。

セクション 2: 新人看護師、看護師としての職歴が 2 年以下の方々

42. 最後に、あなたの新人看護師としての経験を一言で表してください。以下の項目から、もっとも適切であると思われる解答に印☒をつけてください。

- ☐ 非常に良い経験であった。
- ☐ 良い経験であった。
- ☐ どちらともいえない。
- ☐ 悪い経験であった。
- ☐ 非常に悪い経験であった。

セクション 3 次のページから回答を続けてください。

セクション3すべての看護師の方々

あなたの職場環境について

以下の設問について、あなたの現在の仕事状況を最もよく表しているものはどれですか？
もっとも当てはまる場所に印☒をつけてください

	全く そうで ない。	そうで ない。	そうで ある。	大変 そうで ある。
43. 受け持ち患者と過ごす時間が取れるような滴せ つな支援体制がある。				
44. 医師と看護師の仕事上の関係は良好である。				
45. 上司は看護師に対して支援的である。				
46. 看護師向けのスタッフ教育プログラムや継続教 育プログラムに力を入れている。				
47. キャリア開発やクリニカルラダーを活用する機 会がある。				
48. スタッフの看護師がさまざまな方針決定に参加 する機会がある。				
49. 上司は間違いを非難するというより学習の機会 に使っている。				
50. 他の看護師たちと患者ケアに関する問題点につ いて話し合うだけの十分な時間と機会がある。				
51. 質の高い患者ケアを提供するために十分な数の 看護師が配属されている。				
52. 看護師長はよき管理者であり、よきリーダーで ある。				
53. スタッフは看護部長のしていることがよく見 え、かなり身近な存在だと感じている。				
54. 仕事をやり終えるのに十分なスタッフがいる。				
55. 仕事がうまくいったときには賞賛や承認が得ら れる。				
56. 病院の管理部門から高い水準の看護ケアを求め られている。				
57. 看護部長は病院のトップの管理者たちと同等の 力や権威を持っている。				

セクション3すべての看護師の方々

	全く そうで ない。	そうで ない。	そうで ある。	大変 そうで ある。
58. 看護師と医師の間にチームワークが大いにある。				
59. 昇進・昇格や看護師として自己を向上させるチャンスがある。				
60. 看護理念は患者ケアを行う環境にいきわたっている。				
61. 臨床能力に長けた看護師たちと一緒に仕事をしている。				
62. 看護師長は、医師と対立するような状況であっても、看護スタッフの意思決定を支援する。				
63. 病院トップの管理者たちは職員の意見に耳を傾け対応している。				
64. 活発な質保障のプログラムがある。				
65. スタッフの看護師が病院の運営にかかわっている。（たとえば病院の方針を決める委員会への参画）				
66. 看護師と医師は協働して実践に当たっている。				
67. 新採用の看護師を対象にしたプリセプタープログラムがある。				
68. 看護ケアは医療モデルではなく看護モデルに基づいている。				
69. スタッフの看護師は病院や看護部の委員会に参加する機会がある。				
70. 看護師長は、日々生じる問題点について、スタッフに相談している。				
71. すべての患者にたいして、患者ケア計画が記載され、常に見直されている。				
72. 継続的看護ケアを提供するため、患者の受け持ちが決められている。（たとえば、同じ看護師が毎日続けて同じ患者を担当するなど。）				

**設問 43-72 は Aiken によって開発され、Lake によって修正の加えられた NWI-R を使用しています

あなたの今後のキャリア展望について

73. 過去 12 ヶ月の間、あなたは現在の職場を離れることをどのくらい考えましたか？もっとも適切であると思われる解答に印 \square をつけてください。

- ☐ 一度もない。
☐ 過去 12 ヶ月の間何度か考えた。
☐ 毎月数回程度考えた。
☐ 毎週数回考えた。
☐ 毎日考えた。

74. 過去 12 ヶ月の間、あなたは看護師をやめることをどのくらい考えましたか？もっとも適切であると思われる解答に印 \square をつけてください。

- ☐ 一度もない。
☐ 過去 12 ヶ月の間何度か考えた。
☐ 毎月数回程度考えた。
☐ 毎週数回考えた。
☐ 毎日考えた。

ご協力ありがとうございました。.

任意記入

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